Participating Employer

ADMINISTRATION MANUAL

FOR THE
SOUTHERN INTERIOR HEALTH & WELFARE PLAN

Updated: April 2025

SOUTHERN INTERIOR HEALTH AND WELFARE PLAN ADMINISTRATION MANUAL

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SOUTHERN INTERIOR HEALTH AND WELFARE PLAN

This ADMINISTRATION MANUAL has been prepared to provide Employers with procedures which, we believe, will ensure efficiency and economy of effort in the operation of the Plan.

Throughout these procedures, reference is made to forwarding of Enrollment Cards and Billing Forms, etc., to the Plan Administration Office either directly or through your Head Office.

PLAN ADMINISTRATION OFFICE

The Trustees have retained AGA Benefit Solutions to administer the Plan. For companies which initiate documents at a single payroll or personnel office, these documents should be sent directly to the Plan office:

Southern Interior Health & Welfare Plan
c/o AGA Benefit Solutions
301E 675 Cochrane Dr
Markham, ON L3R 0B8
sihwp@aga.ca

You may contact the Plan office by telephone at 800-218-7018 or by FAX at 905-477-2249.

FURTHER INFORMATION

Contact AGA Benefit Solutions by email at sihwp@aga.ca or call 1-800-218-7018 and ask for the Plan Administrator responsible for Southern Interior benefit plan if you have general questions about:

- the terms of the Plan,
- enrollments or forms,
- billing questions
- life insurance or AD&D benefits

If you have questions about Dental and EHC benefits, contact the Pacific Blue Cross (PBC) Dental Call Centre at 604 4192300 or the PBC EHC Call Centre at 604 419-2600. You may also call the toll free number 1-888-275-4672. Claims problems which cannot be resolved at the clerical level may be referred to the more senior level.

For Weekly Indemnity questions, please call BC Life & Casualty Company at 604 419-8080.

If you have trouble getting the information or action you need about any of the above, or if you want to bring something to the attention of the Trustees, contact AGA Benefit Solutions and ask to speak to the Plan Administrator.

HEAD OFFICE

For companies which initiate documents at a number of different locations (or "Divisions") and for which consolidations are required, the documents should be sent to the appropriate office within your organization.

Consolidated reports prepared at that office are forwarded to the Plan Administration office at the above address.

NOTE: In matters regarding claims, the operating division should deal directly with the Plan Administration Office.

NOTE on Divisions: About 1990, there was a project to aligning divisions and seniority lists, at the direction of the Trustees. That is,

One bargaining unit seniority list = One division.

The intention was to be able to identify when a permanent closure occurred, so that we'd know when to trigger any possible contingent liability calculations.
In 2007, an employer requested combining four of their groups into one. The Trustees agreed that the present system is administratively less efficient than allowing seniority lists to be combined for coverage purposes; and the Plan has been managed for a number of years expressly to prevent an overall deficit from occurring. However, the Trustees are concerned that they not take action now which might jeopardize the Plan's position at some future point.

I. ELIGIBILITY

Any employee within the bargaining unit of a Southern Interior forest products operation who is subject to the bargaining authority of Local Unions 1-405, 1-417 and 1-423 of USW, who is not a Part-Time Employee, and whose employer is a member of Interior Forest Labour Relations Association is an eligible employee, including those working a Compressed Work Schedule.

"Part-Time Employee" means a person, employed by an Employer, who is subject to the bargaining authority of the Unions and who neither regularly works four (4) or more days per week nor works on a Compressed Work Schedule.

"Compressed Work Schedule" means the three or more consecutive days in each seven (7) day period in respect of which a person is regularly paid for thirty-two (32) or more hours by an Employer.

"Dependents of eligible employees" include:

A) the employee's spouse,
unless the spouse is an eligible employee and enrolled as a member under the Plan,

and,

B) any child, step-child, adopted child or legal ward of the employee who is
- financially dependent on and living with the Employee or the spouse*

and - unmarried,

and - either - under the age of 21

or - up to and including age 25 in full time attendance at a school or university

and - is not enrolled as a dependent of another eligible employee who is covered by the plan.

and

C) any unmarried mentally or physically handicapped child of an employee to any age who is - financially dependent on and living with the employee or the spouse*

and - is not enrolled as a dependent of another eligible employee who is covered by the Plan.

* If the eligible employee and spouse divorce, coverage for dependent children will continue even though they may reside with the former spouse, as long as they continue to be financially dependent on the eligible employee for support.

II. COMMENCEMENT DATE OF COVERAGE

The rules regarding commencement dates are complicated. They are summarized in the table in Schedule A.

Under the terms of the Southern Interior Health and Welfare Plan every person who is an eligible employee (as defined above) will be covered by and must enroll in the Plan as follows:

Returning to the Bargaining Unit (Supervisors or Union Officials)

Immediately upon return to the bargaining unit in the case of an employee who had been previously transferred by the Company to a supervisory position, (other than temporary supervisors, who remain covered by the Plan while so employed) or immediately upon return to work in the case of an employee who had been on leave of absence whilst appointed or elected to Union Office.

Previously working while covered within 18 months

First day Actively at Work should he produce a Transfer Card indicating that he last worked as a covered employee under the Southern Interior Health and Welfare Plan OR for a member of Forest Industrial Relations OR as a

covered employee under the USW-Forest Industry Health & Welfare Plan No. 2 OR for a member of CONIFER OR for Northwood Pulp and Paper OR for Weldwood of Canada Limited OR for Canfor Limited at any time during the eighteen month period immediately preceding the date he became an eligible employee with your Company.

NOTE: Even though this Transfer Card may indicate that the employee was entitled to lay-off continuation of coverage through his previous employer, and this period of time has not yet expired upon his employment with your Company, he must still be enrolled immediately upon hiring and his previous Southern Interior employer will be notified by the Plan Administration Office.

All Other Employees:

EHC - On the first day of the month following the date of hire.

Life Insurance - on the first day following completion of the Probationary Period.

All Other Benefits - On the first day of the month following the date of completion of the probationary period, provided he is Actively at Work. Otherwise, on the first day of return to work.

“Actively at Work” means that an employee is either actively working on the job site and/or worked his last regularly scheduled work day before the Date of Commencement and is not prevented by Sickness or Injury from commencing Employment. “Working” includes all activities required in the course of employment, including for instance training and orientation.

Summer Students:

In general, summer students are treated the same as other employees in the same situation. That is, new hires should be added for EHC only first of the month following hire.

However, There is a special rule for new employees who are already covered under the Plan through the parent’s coverage. Normally, coverage under the parent ends when they become eligible for EHC, as they are working and no longer considered “financially dependent”. However, this would leave them without dental coverage until their probation ends.

The student who obtains regular bargaining unit employment while an eligible dependent under the terms of the plan will have his dental bridged. That is, claimable expenses incurred after coming off the parent’s coverage and prior to the first of the month following the student’s completion of his or her probationary period will be paid by this plan.

So, upon qualification for EHC only, they should be taken off their parent's EHC coverage. Then, upon completion of probation, they should be fully enrolled in their own right, and taken off their parent's Dental coverage.

When they return to school or otherwise cease to be employed, their coverage would end with no lay-off extension (it's a termination of seniority and not a lay-off), and at that time, if eligible as dependents, be added back to EHC & Dental as dependents of their parents.

SUMMARY OF DATES OF COMMENCEMENT OF COVERAGE

	Type of Employee				
SCHEDULE A	Returning to Bargaining Unit from Supervisory of Union Employment (called "Returning')	Covered Within previous 18 months by SIHWP or other recognized Plan ("Transferred-In")	Other	Disabled*	Recovered*
Life	Date of Return to Employment	First day Actively at Work	First day following end of probation	Date of Disability	Date of return to Employment
AD&D	Date of Return to Employment	First day Actively at Work	First of month following end of probation, OR first subsequent day Actively at Work	Date of Disability	Date of return to Employment
WI	Date of return to employment	First day Actively at Work	First of month following end of probation, OR first subsequent day Actively at Work	Date of Disability	Date of return to Employment
EHC	First of month following return to Employment	First day Actively at Work	First of month following date of hire, OR first subsequent Actively at Work	Date of Disability	Date of return to Employment
Dental	First of month following return to Employment	First day Actively at Work	First of month following end of probation, OR first subsequent day Actively at Work	Date of Disability	Date of return to Employment
NOTE: Laid off employees returning to work following the expiry of their lay-off coverage but within 18 months of last day at work as a covered employee are covered for all benefits on the first day Actively at Work. For a full discussion of the Plan's lay-off provisions, see Section V of the Administration Manual.			*NOTE: Provided coverage was in effect on date of disability, coverage remains in force throughout the WI or WCB Wage Loss period. LTD claimants are provided only with Life insurance coverage. The LTD Plan provides EHC and Dental coverage. If employee recovers and returns to employment with seniority remaining, he is covered immediately.		

III. ENROLLMENT AND BENEFICIARY DESIGNATION

Before an eligible employee starts work, have him complete an Enrollment/Beneficiary Designation Card, as follows:

A. Front of the Card

Enter the NAME OF EMPLOYER and, where appropriate, DIVISION.

Have the employee Print full NAME, SEX (M or F), DATE OF BIRTH and SOCIAL INSURANCE NUMBER. It is extremely important that the SIN is correct. (*) See note below on use of SIN.

Have the employee Print full NAME OF BENEFICIARY, RELATIONSHIP OF BENEFICIARY, and ADDRESS OF BENEFICIARY.

NOTE: Initials (J. Smith) or Husband's name (Mrs. William Smith) are not sufficient. Give the beneficiary's name (Jane Smith).

NOTE: If the beneficiary is a minor, you should name a Trustee, to avoid having the proceeds paid into court and held until a guardian is appointed. The Insurance Carrier recommends the following wording: "My daughter Melissa, with my brother Keith as Trustee acting on her behalf".

The question regarding any previous coverage under the SOUTHERN INTERIOR HEALTH AND WELFARE PLAN or a related plan is extremely important. Have the employee print his previous employer's name and division in the space provided.

The card should be dated, signed by the employee and by a witness to the employee's signature.

The EFFECTIVE DATE OF COVERAGE should be completed by the employer (in accordance with Section II of this manual).

CHECKED BY EMPLOYER should be signed to indicate that the card has been checked for completeness and accuracy.

B. Reverse of the Card

You must complete:

- GROUP NUMBER - your company's Southern Interior Health and Welfare Plan Group Number.

The employee must complete:

- SOCIAL INSURANCE NUMBER (*) See note below on use of SIN.

- NAME, ADDRESS, DATE OF BIRTH, and SEX

- LIST OF DEPENDENTS showing, for each dependent, FIRST NAME and INITIAL, RELATIONSHIP and DATE OF BIRTH.

- The question about coverage as a dependent on the Southern Interior Health & Welfare Plan. (**) See note below on duplicate coverage.

C. Employer Record Card

This card should be completed for your records:

- EMPLOYEE'S NAME (as on the Enrollment Card) and SOCIAL INSURANCE NUMBER (after checking that it is correct). (*) See note below on use of SIN.
- NAME OF BENEFICIARY and RELATIONSHIP from the Enrollment Card. (See section D for change of beneficiary.)
- EMPLOYER NAME and, where appropriate, DIVISION.
- EFFECTIVE DATE OF COVERAGE from the enrollment card.

The Enrollment Card should now be detached from the Employer Record Card and both filed with any other new cards. As all employees will have either immediate full coverage or (for new employees) EHC coverage at the start of the next month, all Enrollment Cards should be submitted with the next monthly billing, and the detached Employer Record Card held in a file of "Active" employees.

*** USE OF SOCIAL INSURANCE NUMBER**

Enrolling employees explicitly authorize the use of their social insurance number for Plan Administration, in accordance with federal legislation.

If an employee refuses to give this authorization he should cross out that sentence ("I hereby authorize...") and initial the change. Leave the "Social Insurance/ID. No." Field blank, and PBC will provide an alternative 9-digit number, which will be shown on his ID cards. The member should be informed in such cases that the alternative number must be used for all claims under the Plan, including those submitted by his dentist, and also that SIN must still be provided with any WI claims, because WI is a taxable benefit.

In such cases, you should wait for the identification number from PBC, and use it on the Employer Record Card in place of SIN. This identification number must then be provided in all correspondence about the employee.

****DUPLICATE COVERAGE**

If a husband and wife are both covered employees in this Plan, they cannot enroll each other as dependents, and only one may enroll each child as a dependent.

If your employee is covered as a dependent by his spouse, notify the spouse's employer to take him off her Plan, and ensure each child is only covered once.

If your new employee is covered as a dependent in this Plan by his mother or father (summer student), after his EHC coverage starts he may continue as dependent for Dental only until his full benefits start.

D. Beneficiary Changes

Covered employees may change their designated beneficiary at any time.

The employee should complete the CHANGE OF BENEFICIARY UNDER GROUP POLICY form in duplicate:

SOCIAL INSURANCE NUMBER, (or i.d. number - see "Enrollment")(please be sure of accuracy).

EMPLOYER NAME and DIVISION.

NAME OF EMPLOYEE

NAME and RELATIONSHIP AND ADDRESS of the new Beneficiary.

DATE and SIGN both forms.

You should Witness the employee's signature on both forms.

Send both copies to the Administrator (or Head Office according to your company's procedures - see pages 4 - 5). One copy of the form will be returned, dated and initialed. Attach that copy to the "Employer Record Card" in your files.

E. Change of Name

Your employee must report any change of name for himself or his designated beneficiary.

The CHANGE OF NAME card should be completed in duplicate;

GROUP NUMBER

SOCIAL INSURANCE NUMBER, (or i.d. number - see "Enrollment")

EMPLOYER Name and DIVISION.

EMPLOYEE Name

Indicate whether the name change applies to the employee or the beneficiary.

Record the SURNAME and GIVEN NAMES both before and after the name change.

Indicate the Reason for change and provide appropriate documents.

DATE, Sign and Witness both forms.

Send both copies to the Administrator (or Head Office according to your company's procedures - see pages 4 - 5). One copy of the form will be returned.

FORM – ENROLMENT CARD and BENEFICIARY DESIGNATION

FORM - ENROLLMENT CARD and BENEFICIARY DESIGNATION

SOUTHERN INTERIOR HEALTH & WELFARE PLAN **ENROLMENT CARD**

Name of Employer _____ Employer # _____

Division _____

Employee's Name(print) _____ Sex _____
Last First Middle

Date of Birth _____ Social Insurance Number/I.D. Number _____
Year Month Day

Beneficiary Full Name _____

(If more than one, indicate % share) Relationship _____

Trustee Designation _____
(Complete only if beneficiary is under 19)

If you were covered by this Plan or another IWA-Forest Industry Health & Welfare Plan within the last 18 months, complete the following:

Last Employer was _____ Division _____

I hereby authorize the use of my Social Insurance number in connection with the administration of the Plan. I agree to the terms of the plan and declare that the information on this card is correct to the best of my knowledge. If the beneficiary appointed above dies before me and I have appointed no other beneficiary I agree that the proceeds due shall be payable in accordance with the provisions of the group insurance contract.

Witness _____

Dated _____ Employee's signature _____

TO BE COMPLETED BY EMPLOYER

Date of hire _____ Effective Date of Coverage* _____
Year Month Day

*Effective date of coverage is in accordance with the Plan Text. Checked by Employer _____ Year Month Day
Signature

Social Insurance /Identity Number

PACIFIC BLUE CROSS™

Pacific Blue Cross, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

Application for Membership in Pacific Blue Cross
PO Box 24715 - Sub - F
Vancouver BC
Canada V5N 5T8

Group No.

Name - Last | First | Initial | Date of Birth (Yr. Mo. Day) | Male ☐ Female ☐

Mailing Address, Apt. No., Street Address, P.O. No., City or Town and Province | Postal Code

	Dependent(s) First Name	Initial	Surname (if different from applicant's)	Relationship to applicant	Date of Birth Yr.	Mo.	Day
01	Spouse						
02	(Oldest First)						
03							
04							
05							
06							
07							

Employees or dependents who are not enrolled when they first become eligible, will not be backdated.

DO NOT WRITE IN THIS AREA

LTD	W	E	L	D	P

Effective Date Yr.	Mo.	Day	Termination Date Yr.	Mo.	Day

Membership and rights to benefits are subject to the laws and regulations of the society.

If you are or have been covered as a dependent on the Southern Interior benefit plan, please indicate

Group and I.D. number _____

Date coverage cancelled (if applicable) _____

_____ Signature _____ Date

FORM – CHANGE OF BENEFICIARY

FORM - CHANGE OF BENEFICIARY UNDER GROUP POLICY

Southern Interior Health and Welfare Plan
Change of Beneficiary Under Group Policy

Complete this form in duplicate and send both copies to the Administrator; one will be returned to you when registered.

Social Insurance / I.D. No. _____

Employer _____

Division _____

Name of Employee _____ Sex _____
Last First Middle

I hereby appoint the following beneficiary under the Group Policy and revoke the appointment of any existing beneficiary thereunder.

Beneficiary Full Name _____

(If more than one, indicate % share) Address _____

Relationship _____

In the absence of any law to the contrary, I hereby reserve the right, without consent of the beneficiary, to change the beneficiary again.

Dated at _____ this _____ day of _____ 20____

Signature of Witness Signature of Employee

Received and registered on behalf of The Trustees of the SOUTHERN INTERIOR HEALTH AND WELFARE PLAN.
This ____ day of _____ 20____
By Pacific Blue Cross
S.I.H.&W. Plan Administrator

FORM - CHANGE OF NAME

CHANGE OF NAME **Southern Interior Health and Welfare Plan**
under Group Policy

Complete this form in duplicate and send both copies to the Administrator; one will be returned to you when registered.

Group Policy No.	**Employer** _____	
	Division _____ Employer# _____	
Social Insurance No.	**Employee** _____	
	First Middle Last	
Please change the name of the ❑ Employee ❑ Beneficiary		
FROM	Family or Surname	
	Given or First Names	
TO	Family or Surname	
	Given or First Names	
Indicate reason for the change of name	❑ Marriage ❑ Other (specify and attach supporting documents)	

Date _____

Signature of Witness Signature of Employee

Received and registered on behalf of The Trustees of the Southern Interior Health and Welfare Plan
Date _____ Initial _____
By Pacific Blue Cross, Plan Administrator

* Pacific Blue Cross, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

IV. TERMINATION OF COVERAGE

An employee will cease to be covered by the Plan in accordance with the following Schedule B.

When an employees coverage is terminated, the Termination of Coverage Card (reverse of the Employer Record Card) should be completed, showing DATE OF TERMINATION OF COVERAGE and NAME OF EMPLOYER, dated and signed. The Termination Card for an employee whose coverage is terminated should be forwarded with the billing for the month immediately following the month in which the termination is effective as outlined in Section VI of the Administration Manual.

NOTE: Terminations should be received within 30 days of effective date. If they are late, if any claims were paid, your company will be billed for the cost of the claim.

LIFE INSURANCE CONVERSION

An employee whose Group Life Insurance coverage is terminated has the right to convert to an individual policy without medical evidence of insurability. To exercise this right, he must make proper application to Canada Life and pay the appropriate premium within 31 days from the date of termination of his Group coverage.

The 31-day "Conversion Period" starts on the exact date of termination of employment or exact date of lay-off, or exactly 3 months or 6 months after exact date of lay-off if eligible for lay-off coverage.

Those interested should be given a completed "Group Life Conversion Privilege Notification" and should be advised to consult with a financial security advisor to convert their group life coverage. This will help ensure they receive the professional advice required to make informed decisions when applying for individual life insurance. This can be a very valuable option, especially for someone not in good health, and employees should be reminded of their right. Someone in good health, particularly a non-smoker, should find out if they would qualify for a lower rate based on medical evidence.

EXTENDED HEALTH CARE and DENTAL PLAN FOR RETIRING MEMBERS

Pacific Blue Cross used to offer an individual Extended Health Care Plan specifically for retiring USW members who were covered under the Southern Interior Health & Welfare Plan.

This was found to be ineffective and now only standard PBC individual plans are offered to all terminating members. These may also include Dental coverage.

An individual plan is a direct contract between PBC and the retiring member, and the contract does not involve the Participating Employers, Local Unions, or Trustees in any way, except that we make retiring employees aware of the option.

Important points to note:

- "Conversion Plans" will waive most pre-existing condition exclusions. As a result, they are more expensive than other Individual Plans. To be eligible for a Conversion Plan, employees must be covered up to the date of termination and must enroll within 60 days of termination. Coverage will be the first of month following the date of termination.

- Benefits differ from those offered under the Southern Interior Health & Welfare Plan. They are fully described in the individual contract.

- Please make your retiring employees aware of this option. Enrollment cards, application and rate information, and contracts for this purpose are available from Pacific Blue Cross (PBC).

  For details, the employee may contact the Individual Plans / Travel Sales Department at 604 419-2200, or go to pac.bluecross.ca/individual and click on "Find a Plan".

SUMMARY OF DATES OF TERMINATION OF COVERAGE

	EMPLOYEES OTHER THAN DISABLED EMPLOYEES				
	Laid-off With Less Than 4 Months Seniority	Laid-off With 4 or More Months Seniority	Terminated, Retired or Deceased	On approved Leave of Absence	**DISABLED EMPLOYEES**
Life	31 days following exact date of lay-off (Conversion period)	31 days following exact date lay-off coverage terminates (Conversion period)	31 days following exact date of termination or retirement (Conversion period), or date of death	31 days following exact date LOA ends (Conversion period)	31 days following exact date Disability ends, or age 65
AD&D	Exact date of lay- off	Exact date lay-off coverage terminates	Exact date of termination, retirement or death	Exact date LOA ends	Exact date of cessation of WCB Wage Loss(*) or WI
WI	Exact date of lay- off	Exact date lay-off coverage terminates	Exact date of termination(unless disabled), retirement or death	Exact date LOA ends	Date of cessation of WCB Wage Loss(*) or WI payments
EHC	End of month in which lay-off occurs	End of month in which lay-off coverage terminates	End of month in which termination, retirement or death occurs	End of month in which LOA ends	End of month in which WCB Wage Loss(*) or WI payments cease (5)
Dental	End of month in which lay-off occurs	End of month in which lay-off coverage terminates	End of month in which termination, retirement or death occurs	End of month in which LOA ends	End of month in which WCB Wage Loss(*) or WI payments cease (5)

NOTES

1) On the date a benefit is terminated, all employees are terminated for that benefit.
2) "Terminated" employees include those granted leave of absence under Article XI, Section 3(a) of the Master Agreement (appointed or elected to Union office), or transferred to a supervisory position.
3) There are several conditions which govern continuation of life insurance while disabled (see Section IX(B)).
4) For Dental and EHC, dependents terminate on the date of member termination, or, if earlier, on
   - date of dependent's death
   - end of month in which he no longer meets the definition of dependent
5) If a Disabled Employee's employment ends while on WCB Wage Loss(*) or WI, then
   - AD&D ends on the day employment ends.
   - Dental and EHC end at the end of the month in which employment ends.
   - WI and Life insurance continue as if employment had not ended. If the employee took severance as part of a permanent closure or reduction, then the employer pays a reduced monthly contribution, otherwise no contributions are due. In February, 2009, the Trustees agreed with the Plan office that members whose retirement is facilitated by the Community Development Trust Program are treated the same as other retiring members for this purpose.

6) Coverage while awaiting LTD Adjudication.

- From the minutes of October 3, 1990: "the Plan provide[s] coverage, without employer contributions, for EHB, Dental and Group Life for disabled members whose weekly indemnity or WCB Wage Loss(*)benefits have ended, provided an application has been filed with the IWA Forest Industry LTD Plan, until the LTD Plan has adjudicated it, for up to three months. If adjudication is not complete after three months, [PBC] is to refer to the Trustees for possible extension."
- In the minutes of August 9, 2001, it was noted that a member's LTD claim was denied but he filed an appeal, and asked that benefits be continued a further 3 months. His coverage was continued until his LTD appeal was exhausted. The Trustees ratified the continuation, and the implication is that similar applications would be considered in the future.
- Also on August 9, 2001, the Trustees confirmed that requests for coverage continuation while awaiting LTD Adjudication (or appeal) should be forwarded to the Claims Appeals Committee.

(*) Wherever the term "WCB Wage Loss" is used in this Administration Manual, it is understood to include WCB Income Continuity or rehabilitation allowance.

FORMS - EMPLOYER RECORD CARD

TERMINATION OF COVERAGE CARD

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

EMPLOYER RECORD CARD AND TERMINATION OF COVERAGE CARD

Employee's name _____ Employer # _____

Social Insurance /I.D. No. _____

Name of Beneficiary _____ Relationship _____

Address _____

Employer _____ Divison _____

Effective Date of Coverage _____

Year Month Day

Date of layoff	Date returned to work	Date of layoff	Date returned to work	Date of layoff	Date returned to work

Reason for termination _____

_____ Date of termination coverage _____

Year Month Day

Coverage terminates upon cessation of active employment except as outlined in the Plan Text.
This will confirm that a transfer card has been issued to the employee whose name appears above.

Dated _____ Signed by _____

S.I.H.W.P. 52 - 10 - 200 Rev12/07 CUPE 1816

FORMS – GROUP LIFE CONVERSION

canada life

Group Life Conversion Privilege Notification

Plan Administrator Section: PART 1

Complete the fields below, give one copy of this form to the plan member upon termination or reduction of group life insurance, and keep a copy for your files.

1. Group life insurance policy - advisor information (if applicable)

Advisor	Telephone Number ( )	Fax No. ( )
Address	Email Address	

2. Plan member/spouse information

Plan Member's Name	Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other	Date of Birth (month/day/year)
Spouse's Name (if eligible for spousal conversion)	Gender ☐ Male ☐ Female ☐ Undisclosed ☐ Other	Date of Birth (month/day/year)
Address	Telephone Number ( )	

3. Group life insurance information

Group life policy name:

		Policy no.:	Reduced/terminated amount:	Combined (max $200,000 per person) conversion maximum	Date insurance reduced/terminated (month/day/year)
Plan Member	Basic		$		
	Optional		$	$	
	Supplementary		$		
Spouse	Basic		$		
	Optional		$	$	

4. Plan administrator information

Plan administrator's name (please print)	Telephone number ( )	Email
Plan administrator's signature		Date (month/day/year)

Plan Member/Spouse Section: PART 2

If your Canada Life group life insurance has been terminated or reduced, you may be able to purchase an individual life insurance conversion policy, without providing medical evidence of insurability. The group life conversion application must be received by Canada Life within 31 days after your group life coverage terminates or reduces. Here's what you need to do to convert your group life insurance:

Step 1: Give this completed Group Life Conversion Privilege Notification form to your advisor.

a) If you do not have an advisor or your advisor is not licensed to sell Canada Life products, please visit https://canadalife.com/contact-us/existing-customer/workplace/life-insurance-convert-personal-product.html.

After you submit the form, an advisor will contact you and explain the group life conversion options available so you can make the right choice based on your insurance needs.

b) You may also speak to a customer service representative by calling: 1-888-252-1847. The customer service representative will assist in connecting you with an advisor.

c) You may also reach us by email: stay_covered@canadalife.com.

Step 2: After you have decided on your group life conversion option, the advisor will submit the completed and signed application, with the first full premium payment to Canada Life for processing. This application process must be completed within 31 days after your group life insurance terminates or is reduced.

M5725-11/24 Clear

V. LAY-OFF

An employee who is laid-off is entitled to and will be granted continuation of coverage for a period of six months provided he has one or more years' seniority or three months provided he has less than one year but four or more months' seniority.

The Employer Record Card for a laid-off employee whose coverage is continued should be removed from the file of "Active" employees and filed with those of other laid-off employees in order of the month in which coverage will terminate. Upon termination of coverage, the Termination of Coverage Card should be forwarded to the Administrator as outlined in Section VI of this manual..

LAY-OFF EXTENSION IS COUNTED FROM EXACT DATE LAID OFF

See "COVERAGE DURING LAY-OFF - EXAMPLES" on the next page, and "SUMMARY OF DATES OF TERMINATION OF COVERAGE" in this manual.

RETURN FROM LAY-OFF

The following rules regarding extension of lay-off coverage, and reinstatement of lay-off coverage in cases where one of your laid-off employees returned to work are complicated. For explanations and examples see "COVERAGE DURING LAY-OFF - EXAMPLES" on the next page.

Return to regular employment (no known date of future lay-off)

Full coverage is restored, and full lay-off coverage is reinstated.

Return to work for a temporary period - 10 days worked within a 30 day period.

Working 10 days or more within a 30 day period, within the seniority period, results in a full reinstatement of original lay-off extension (3 or 6 months, depending on seniority), in the event of a subsequent lay-off.

Return to work for a temporary period - less than 10 days within a 30 day period.

If the return to work (for less than 10 days) occurs before the expiry of layoff coverage, it earns coverage for that month, in effect extending existing lay-off coverage by one month.

If the return to work occurs after the expiry of the lay-off coverage (3 or 6 months, depending on seniority), coverage starts immediately on return to work, and continues until the end of the month.

Note: Contributions are to be paid for that month if the return occurs from the 1st to the 15th of the month, inclusive. No contributions are required if the return occurs from the 16th to the 31st, inclusive.

COVERAGE DURING LAY-OFF - EXAMPLES

SCHEDULE C

Member with 2 years seniority is laid off January 7.

- Lay off extension is until July 7.

Member returns to work March 7, 8, 9.

- This “buys” March coverage
- Lay-off extension is now until August 7.

Member does not return to work before August 7

- Coverage terminates August 7 for AD&D, WI.
- Coverage terminates August 31 for EHC, Dental
- Coverage terminates September 7 for Life (see section IV)
- Contributions are due through August, even though the member is not covered for August 8 - 31 for some benefits.

Member works September 12, 13, 14

- Coverage starts September 12 for all benefits.
- Coverage terminates September 30 for all benefits.
- Contributions are due for September even though the member is not covered for September 1 - 12.

Member works October 24 - 28

- Coverage starts October 24 for all benefits
- Coverage terminates October 31 for all benefits.
- Contributions are not due for October, since start date is later than 15th.

Member works November 21 - December 9

- By working 10 or more days in 30, the member’s lay-off coverage is reinstated.
- Coverage starts November 21 for all benefits.
- Contributions are not due for November, since start date is later than 15th.
- Lay-off extension is now until June 9 and contributions are due from December 1 through to June 30.

EI Job-Share

Sometimes, in order to maintain crews during downturns, with reduced impact on personal income and future EI eligibility, arrangements are made between an employer, the local union, and employees, whereby two employees essentially share one job. For instance, Employee A might work 3 days in week 1 and claim the other 2 days as EI unemployed benefits; Employee B would work the other 2 days in week 1 and claim the

other 3 days as EI unemployed benefits, Then in week 2 the days would be switched, and so on. There are other possibilities.

This is essentially the same as a common situation where an employee without steady employment has an open EI unemployed claim, reports his days of work, and is paid EI for days not worked. Total EI entitlement is stretched out by days worked. From the Plan's point of view,

- v' The member is laid off – recalled – laid off – recalled - laid off ... and so on.
- v' Under regular lay-off and recall rules, he continues as a fully covered employee, with 6-month coverage 'stretched' by each month in which a day is worked, and continually reinstated whenever at least 10 days worked in a month.
- v' If disabled, eligible for full WI benefits just like any other employee. IT IS MOST IMPORTANT for the member to STOP his EI claim, because (a) the WI benefit is based on a full week of disability; and (b) to protect EI eligibility against future events.

LAY-OFF AND TRANSFER CARD FOR LAY-OFF OR TERMINATION

A covered employee who is laid-off or whose employment is terminated must be given a Transfer Card, completed as follows:

1) Insert full name of employee, Social Insurance Number (or id. number - see "Enrollment") and last day worked.

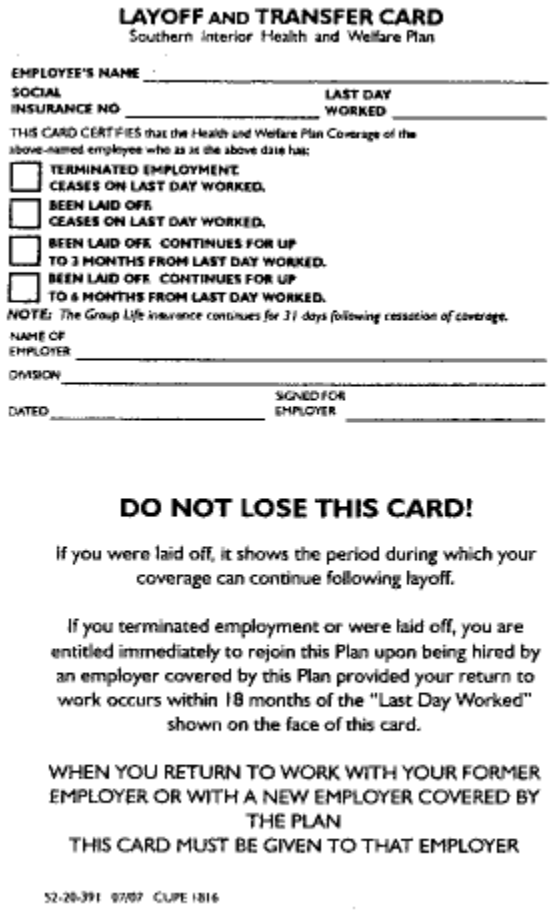
2) Check the appropriate section respecting lay-off or termination to indicate the correct category of the employee concerned.

3) Insert employer's name and division, date and sign card.

   The card should then be handed to the employee with the request that he safeguard it carefully for presentation upon re-employment or upon employment elsewhere.

NOTE: THIS LAY-OFF AND TRANSFER CARD IS A VERY IMPORTANT DOCUMENT IN THE ADMINISTRATION OF THE PLAN INASMUCH AS IT PROVIDES POSITIVE PROOF, BOTH TO THE EMPLOYEE AND TO ANY NEW EMPLOYER, OF THE CORRECT STATUS OF THE EMPLOYEE UNDER THE PLAN.

FORM - LAY-OFF AND TRANSFER CARD



LAYOFF AND TRANSFER CARD
Southern Interior Health and Welfare Plan

EMPLOYEE'S NAME _____

SOCIAL INSURANCE NO _____ LAST DAY WORKED _____

THIS CARD CERTIFIES that the Health and Welfare Plan Coverage of the above-named employee who as at the above date has:

- ☐ TERMINATED EMPLOYMENT. CEASES ON LAST DAY WORKED.
- ☐ BEEN LAID OFF. CEASES ON LAST DAY WORKED.
- ☐ BEEN LAID OFF. CONTINUES FOR UP TO 3 MONTHS FROM LAST DAY WORKED.
- ☐ BEEN LAID OFF. CONTINUES FOR UP TO 6 MONTHS FROM LAST DAY WORKED.

NOTE: The Group Life insurance continues for 31 days following cessation of coverage.

NAME OF EMPLOYER _____

DIVISION _____

DATED _____ SIGNED FOR EMPLOYER _____

DO NOT LOSE THIS CARD!

If you were laid off, it shows the period during which your coverage can continue following layoff.

If you terminated employment or were laid off, you are entitled immediately to rejoin this Plan upon being hired by an employer covered by this Plan provided your return to work occurs within 18 months of the "Last Day Worked" shown on the face of this card.

WHEN YOU RETURN TO WORK WITH YOUR FORMER EMPLOYER OR WITH A NEW EMPLOYER COVERED BY THE PLAN
THIS CARD MUST BE GIVEN TO THAT EMPLOYER

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VI. BILLINGS AND REMITTANCE

COVERAGE OF EMPLOYEES AND REQUIRED CONTRIBUTIONS

The general principle is that all contributions are paid on a monthly basis, for all employees covered during the month.

- For employees whose coverage commences during the month, payment is made if the effective date is from the 1st through the 15th, inclusive.
- If coverage commences from the 16th through 31st, no payment is required.

For employees whose coverage ends during the month,

- payment is made if the date coverage ends is from the 16th through 31st.
- Payment is not required for those employees whose coverage terminates from the 1st through the 15th, inclusive.

Other than the 1 - 15, 16 - 31 rule, no adjustment or pro-rating is made for coverage for part of a month.

A) New Employees

This applies to new employees, or previous employees who have not worked as a covered employee within the last 18 months (see page 7 for qualifying employment).

EHC coverage starts on the first of the month following the date of hire, provided employee is “Actively at Work”. Life Insurance takes effect the day after probation is completed. The remaining benefits, WI, AD&D, and Dental, take effect on the first of the month following the end of probation, again provided employee is “Actively at Work”.

For example, assume a new employee starts on January 30 (Monday) and works a regular Monday - Friday shift without interruption.

- First of month following date of hire is February 1. EHC coverage starts February 1, and EHC contributions must be paid for the month of February.
- EHC contributions must be paid for the month of March.
- Member’s 30th day of work is March 10 (Friday). This satisfies the probation requirement of 30 days worked within 90 days.
- First day following end of probation is March 11. Life Insurance coverage begins on that date, but no additional contribution is due for March.
- First of month following end of probation is April 1. Although this is a Saturday, the member is “Actively at Work”, having worked his last scheduled day (March 31).

Coverage for AD&D, WI, and Dental therefore starts on April 1. Since Life and EHC are already in effect, the member now has full coverage. Full contributions are due for the month of April.

Occasionally an employee who was previously a casual becomes a regular employee and qualifies for full benefit coverage. Coverage for all benefits (with the exception of EHC) will then start on the first of the month following completion of the probationary period. EHC will start on the first of the month following the date that the employee became available for full time employment.

B) “Transferred-In” Employees

This applies to employees who, within the last 18 months, were covered under the Southern Interior Health and Welfare Plan, or one of the designated Plans with which Southern Interior has portability, either as an active employee or under the disability provisions of the Plan. Note that this definition applies equally to laid-off employees of other companies, or to your own laid-off employees whose lay-off coverage has expired.

All benefits start on the first day of work.

For example, assume a transferred-in employee starts on March 6 (Monday), and works a regular Monday - Friday shift without interruption.

- First day actively at work is March 6. All benefits start on that day, and March contributions are due, since employee's coverage date was between March 1 and 15, inclusive.

For example, assume another transferred-in employee started on March 20 (also Monday), and also works a regular Monday - Friday shift. All benefits start on March 20, the only difference from the above example is that March contributions are not due, since his coverage date was between March 16 and 31, inclusive.

C) Termination of Coverage

Assume an employee with three years seniority is laid off on August 15th, and is not recalled. His lay-off coverage is 6 months.

- Coverage for AD&D and WI terminates February 15th.
- Coverage for Dental and EHC terminates February 28th.
- Coverage for Life terminates March 15th (see section IV)

- Contributions are due for February, but not March. Even though some benefits terminate between February 1 and 15, significant benefits remain until the end of the month. However, no charge is made for the Life Insurance extension.

Assume another employee quits on September 22nd. Termination of employment is immediate, and no lay-off extension applies.

- Coverage for AD&D and WI terminates September 22.
- Coverage for Dental and EHC terminates September 30.
- Coverage for Life terminates October 22 (see Section IV).
- Contributions are due for September, but not for October.

D) Leave of Absence

Full coverage remains in effect, and full contributions must be paid, for employees on Leave of Absence due to

- Disability while in receipt of Weekly Indemnity or WCB Wage Loss benefits (but see section below on Disabled Employees).
- Suspension
- Pregnancy
- Apprenticeship under a provincial apprenticeship program
- Bereavement
- Jury duty

- Union business
- Campaigning as a candidate for federal, provincial, or municipal elective public office.
- Part-time, intermittent service in the capacity of an elected or appointed municipal officer.

While on leave of absence for compassionate reasons, or for educational or training purposes (other than a provincial apprenticeship program), or extended vacation, all benefits except Weekly Indemnity continue, as follows:

- Life and AD&D premiums paid by employer
- Dental and Extended Health premiums paid by employee
- It is the employer's responsibility to collect and remit the employee's portion to the Plan.

E) Disabled Employees

The possibilities for members with lengthy disabilities are:

1) member is injured off the job or suffers non-occupational illness:

Period of disability	**Employee's Benefits**	**Employer's Contribution**
Weeks 1 – 26	all	normal rate
Weeks 27 – recovery or age 60 while on LTD	Life Waiver (SIHWP) Dental, EHC, MSP (LTD Plan)	nothing
Age 60 - age 65	Life Waiver (SIHWP)	nothing

2) member is injured on the job:

Period of disability	**Employee's Benefits**	**Employer's Contribution**
Weeks 1 – 52	all	normal rate
Weeks 53 - PPD	all	nothing
PPD – recovery or age 60 while on LTD	Life Waiver (SIHWP) Dental, EHC, MSP (LTD Plan)	nothing
Age 60 - age 65	Life Waiver (SIHWP)	nothing

There is an important distinction between

- the employee's entitlement to benefits, which continues while the member is on "short-term" benefits, whether from the Plan or from WCB; and
- the employer's requirement to pay contributions, which ends after 52 weeks of short term benefits have been paid. Due to attempted return to work or periods when no benefit is payable, this sometimes

takes longer than 52 weeks elapsed time. The "cap" of 52 weeks for employees with occupational disabilities was established by the Trustees on August 22, 2002, effective October 1, 2002.

Note that for non-occupational disabilities, the member will go on LTD after 26 weeks of WI. The employer's requirement to pay contributions ends at that time. BUT, for occupational disabilities, the employer's obligation to pay contributions continues up to 52 weeks of WCB Wage Loss.

When completing the Billing Form please show the month, your Company's NAME, DENTAL GROUP NO., DIVISION (where appropriate), and MAILING ADDRESS. When completing the remainder of the form, you may wish to refer to the notes and examples at the end of this section, headed "Coverage of Employees and Required Contributions".

A. CALCULATE NUMBER OF COVERED EMPLOYEES

1. Enter number of employees covered during previous month from the previous month's Billing Form (i.e. Item 5).

2. Enter number of new and returning employees who became covered for <u>full benefits</u> since you completed the previous month's bill. List additions on reverse of form in the section "Additions or Transfers - All Benefits."

NOTE: Do not count employees previously covered for EHC-only, who are now eligible for all benefits, but <u>do</u> list them on the reverse, with "Y"es under "EHC Only Last Month".

NOTE: If a new employee becomes eligible immediately because he was previously covered within 18 months (see Section II(B) of this Administration Manual) while still on lay-off coverage under his previous employer, a duplicate payment may result if both you and the previous employer pay for the same month. If so, the administrator will allow the appropriate credit by means of an Administrator's Adjustment Memo. The previous employer will pay for the month if hire date is 16-31. You, as the new employer will pay if hire date is 1-15.

NOTE: On the Enrollment Card and on the reverse of the form, the "Effective Date of Coverage" is the exact day the employee's coverage under the Plan commences. See Section II of this Administration Manual.

3. Number of employees who became eligible for <u>Extended Health Care only</u> - list on reverse of form, in the section "ADDITIONS - EXTENDED HEALTH CARE ONLY". When these members become eligible for all benefits you will list their names again as "ADDITIONS OR TRANSFERS - ALL BENEFITS".

4. Number of employees whose coverage ceased refers to those employees whose coverage under the Plan terminated since you completed the previous month's bill - list terminations on reverse of form.

   NOTE: On the Termination of Coverage Card and on the reverse of the form, the "Date of Termination of Coverage" is the exact day the

employee's coverage under the Plan ceases. See Section IV of this Administration Manual.

5. Is the sum of Items 1, 2 and 3, minus Item 4.

B. CALCULATE AMOUNT OF CONTRIBUTION

Having calculated the number of employees covered for the current month, break them down according to the type of coverage. Each type of coverage has a different rate, as determined by the Trustees from time to time (see "RATES" section which follows.

a) contributions due for employees who are covered for all benefits under the plan, times the monthly rate.

b) contributions due for employees who are covered for Extended Health Care only under the Plan, times the monthly rate.

c) contributions due for employees who are on leave of absence for Compassionate, Educational or Training purposes, times the monthly rate. List these employees on reverse of form.

d) Contributions for employees in special, approved, situations - be sure to attach a detailed explanation.

NOTE: an example is an employee whose WI or WCB Wage Loss has expired but whose LTD claim is still being adjudicated. Their Dental and EHC coverage is continued at no cost to the employer (i.e. rate = $0) for up to three months pending LTD adjudication. An employee in this section would be reported as "1 times $0 = $0".

TOTAL - add the above 4 items. The total number of employees must be the same as item 5.

7. "Adjustments for previous month" is the amount by which the billing is to be adjusted as a result of corrections (additions, terminations or change of coverage) with respect to previous billings. Please make all necessary adjustments, and attach a detailed explanation and the necessary Enrollment or Termination Card(s). From time to time the Administrator may instruct you to make certain adjustments by sending an Administrator's Adjustment Memo. Retain the original and attach the copy to the Billing Form.

8. TOTAL PAYMENT ENCLOSED is the sum of Items 6 and 7.

NOTE: Make all cheques payable to "SOUTHERN INTERIOR HEALTH & WELFARE PLAN" or "S.I.H.W. PLAN".

Forward the original of the Billing Form with the full payment and all Termination of Coverage Cards, Enrollment Cards, Administrator's Adjustment

Memo, or other adjustment explanation (if any) to the Administrator (or Head Office according to your Company's procedures - see page 1).

Payment and all enrollment information must be <u>received by the administrator</u> by the end of the month for which payment is being made. <u>Interest is charged on overdue accounts.</u>

REVERSE OF BILLING FORM

Please be sure to complete:

ADDITIONS and ADDITIONS OR TRANSFERS

NAME, SOCIAL INSURANCE NUMBER and EFFECTIVE DATE of coverage for all employees added to the billing.

TERMINATIONS

NAME, SOCIAL INSURANCE NUMBER (or id. number - see "Enrollment"), DATE OF TERMINATION and REASON FOR TERMINATION for all employees removed from the billing.

NOTE: The REASON is especially important for employees terminated following a period of total disability. This employee may be eligible for a Waiver of Premium Disability Benefit.

EMPLOYEES ON LEAVE OF ABSENCE FOR COMPASSIONATE, EDUCATIONAL OR TRAINING PURPOSES.

NAME, SOCIAL INSURANCE NUMBER (or id. number - see "Enrollment") and DATE LEAVE GRANTED ("FROM") expected date of return ("TO") are required for any employee being paid for at the reduced contribution rate.

RATES

As noted above in point "6. Current Month", there are different rates for different classes of coverage. Following are notes on how the rates are set by the Trustees. Note that in each case, the "cost" is the <u>projected</u> cost per member per month, as estimated by the Plan's actuary based on past experience, recent trends, and the expected impact of any benefit changes.

<u>a1)</u> **<u>All benefits, full-time</u>**

The rate is the sum of the costs for each line of benefit, PLUS the cost of Plan overhead ("expenses") PLUS OR MINUS, if applicable, any Reserve Loading (the projected amount to run-off an accumulated surplus or amortize an accumulated deficit).

<u>a2)</u> **<u>All benefits, permanent part-time</u>**

Under the cost-sharing letter of understanding for permanent part-time employees, the Employer pays 1/2 the full cost of benefits, expenses and Reserve Loading, as described under (a1) above.

The Employee pays the other 1/2 of benefits, but excluding

v' WI, because under the letter of understanding, permanent part-time employees are coverage for only 1/2 of the WI benefit, to be paid by the employer; and

v' Reserve Loading, because historically the surpluses or deficits were mostly due to fluctuations in WI claims experience, and permanent part-time members don't pay WI.

b) Extended Health Care only

The rate is simply the cost for Extended Health Care. Expenses and Reserve Loading are not included. The EHC-only rate has long been a feature of the Plan, and was established before expenses and Reserve Loading were formally included in contribution rate setting.

c) Leave of absence

Employees on LOA are covered for all benefits except WI.

The Employer pays the cost of AD&D, Life Insurance (including funding for "Waiver") and 1/2 the cost of expenses.

The Employee on LOA pays the cost of Dental, EHC, and 1/2 the cost of expenses.

There is no Reserve Loading, because historically the surpluses or deficits were mostly due to fluctuations in WI claims experience, and members on LOA are not covered for WI.

d) Employees in special, approved, situations

There may be others, but two are documented:

Members on disability who take a severance package

These members, while in receipt of WI or WCB Wage Loss, remain covered for WI and Life Insurance (including "Waiver") only, so the Employer pays the cost of those benefits, plus expenses.

Dependents of deceased member

These dependents remain covered for Dental and EHC only, so the Employer pays the cost of those benefits. Expenses are not included no compassionate grounds.

BILLING FORM (FRONT)

SOUTHERN INTERIOR HEALTH AND WELFARE PLAN

Billing Form for the Month _____ 20_____

(Must be delivered with payment to the Plan Office not later than the last day of the month for which payment is being made. Interest is charged on late payments.)

NAME OF EMPLOYER _____ DENTAL GROUP No. _____

DIVISION _____

MAILING ADDRESS _____

_____ POSTAL CODE _____

A. CALCULATE NUMBER OF COVERED EMPLOYEES

1. Number of Employees covered during previous month (Item 5 on previous billing) ..... _____
   (Includes previously covered for EHB, now covered for all benefits. List on reverse.)
2. PLUS Number of new or returning Employees covered for All Benefits + _____
   (Enclose Enrollment Cards and List on reverse) .....
3. PLUS Number of new or returning Employees covered for Extended + _____
   Health Benefits only (Enclose Enrollment Cards and List on reverse) ....
4. MINUS Number of Employees whose coverage terminated since – _____
   previous report (Enclose Termination Cards and List on reverse).....
5. EQUALS Total Number of covered employees during current month..... = _____

B. CALCULATE AMOUNT OF CONTRIBUTIONS

6. Contributions for current month	Number	X	Rate	=	Payment
a. Employees covered for all benefits....	_____	X	_____	=	$_____
b. Employees covered for EHB only.....	_____	X	_____	=	$_____
c. Employees on leave of absence for compassionate, educational or training (List on reverse).....	_____	X	_____	=	$_____
d. Other (Attach detailed explanation)...	_____	X	_____	=	$_____
TOTAL of a. b. c. & d.	_____			=	$_____

7. Adjustments for previous month (CR or DR) (please explain) ..... = $_____

8. **TOTAL PAYMENT ENCLOSED** ..... = $_____

(GST included in total. Reg. #R129016545)

MAKE CHEQUE PAYABLE TO: SOUTHERN INTERIOR HEALTH AND WELFARE PLAN
AND REMIT, with this form, Termination Cards, Enrollment Cards, or adjustment explanation, if any.

TO:
YOUR HEAD OFFICE
for consolidation with the Billing Forms from other divisions of the Company if your Head Office has so instructed.

OR TO:
SOUTHERN INTERIOR HEALTH AND WELFARE PLAN
c/o PACIFIC BLUE CROSS
P.O. Box 24715, Sub-F
Vancouver, BC V6N 5T8
TEL: (604) 419-2420 FAX: (604) 419-2684

*Pacific Blue Cross, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans.

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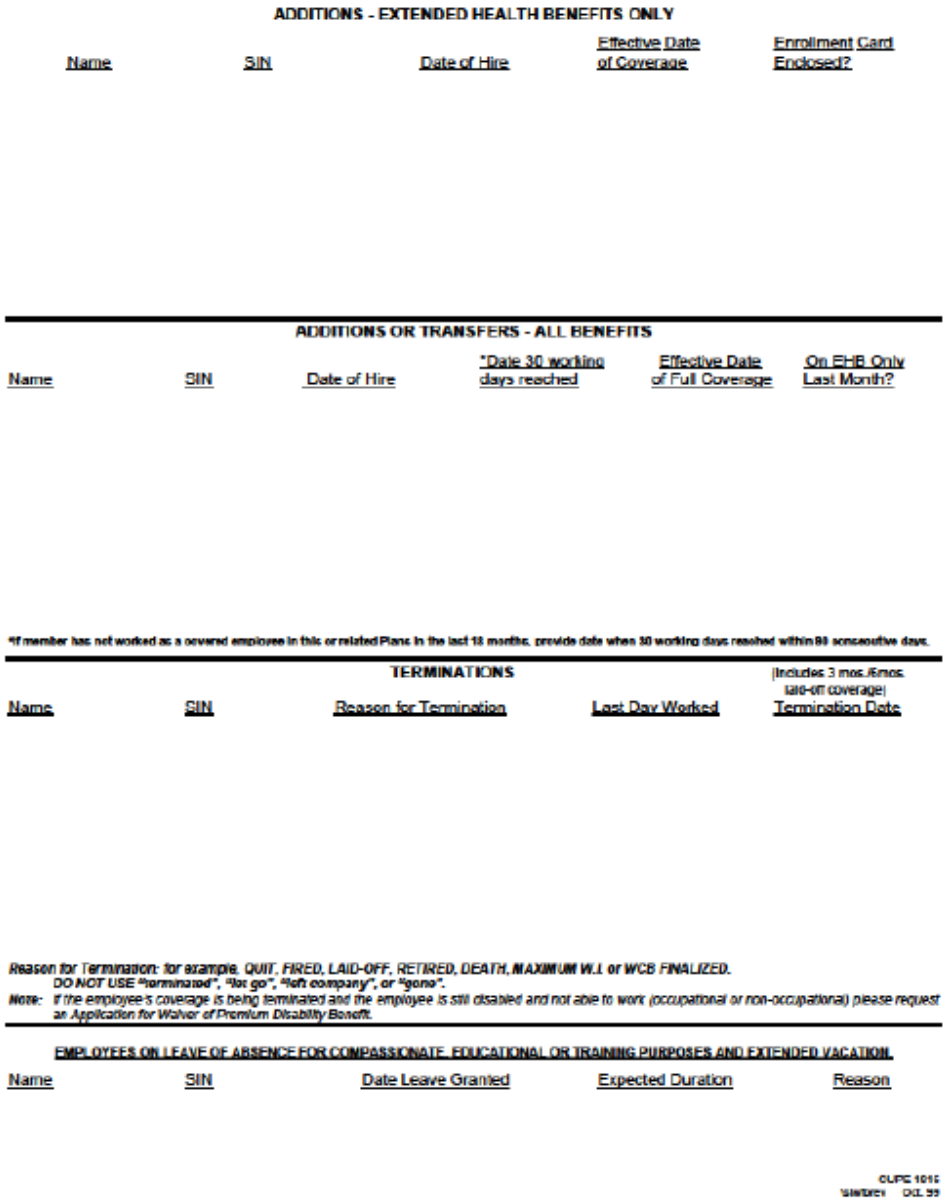
Revised: 08/17/99

BILLING FORM (REVERSE)



ADDITIONS - EXTENDED HEALTH BENEFITS ONLY

Name	SIN	Date of Hire	Effective Date of Coverage	Enrollment Card Enclosed?

ADDITIONS OR TRANSFERS - ALL BENEFITS

Name	SIN	Date of Hire	*Date 30 working days reached	Effective Date of Full Coverage	On EHB Only Last Month?

*If member has not worked as a covered employee in this or related Plans in the last 18 months, provide date when 30 working days reached within 90 consecutive days.

TERMINATIONS

Name	SIN	Reason for Termination	Last Day Worked	(Includes 3 mos./6mos. late-off coverage) Termination Date

Reason for Termination: for example, QUIT, FIRED, LAID-OFF, RETIRED, DEATH, MAXIMUM W.I. or WCB FINALIZED.
DO NOT USE "terminated", "let go", "left company", or "gone".
Note: If the employee's coverage is being terminated and the employee is still disabled and not able to work (occupational or non-occupational) please request an Application for Waiver of Premium Disability Benefit.

EMPLOYEES ON LEAVE OF ABSENCE FOR COMPASSIONATE, EDUCATIONAL OR TRAINING PURPOSES AND EXTENDED VACATION

Name	SIN	Date Leave Granted	Expected Duration	Reason

CLPC 1015
Version Oct. 99

VII. CLAIMS

A. WEEKLY INDEMNITY BENEFIT

When a claim is to be made to this benefit the form headed “Claim for Employee Weekly Indemnity Benefits” should be fully completed by the Employee, Employer and Attending Physician. To eliminate delay in the payment of the benefit, it is essential that this form be correctly and fully completed.

The employee must first complete the “Employee’s Statement”. The employer must then complete the “Employer’s Statement”, and the

employee's doctor must complete the "Attending Physician's Statement". Typically, the employee will return the completed claim form to you for forwarding to the Plan Administration office. Alternatively, the forms may be sent directly to the Plan by the employee.

NOTE: Question 14 of the "Employees Statement" (Summary of educational and work experience), and the description of job duties requested in the "Employer's Statement" are not normally required if the disability is expected to be of brief duration. They are especially important where the disability is severe and likely to be prolonged, particularly if in the judgment of the attending physician the employee is a suitable candidate for a vocational rehabilitation program (Question 23). Since the claim form may not go through the employer's office after the "Attending Physician's Statement" has been completed (see above), it may be necessary to consult by telephone when deciding how much information to supply.

Weekly Indemnity benefit cheques are issued every two weeks once a claim has been established. These cheques are mailed to the Employer for delivery to the disabled member.

From time to time BC Life & Casualty will require completion of an "Additional Weekly Indemnity Benefits' form which also includes a "Supplementary Report of Attending Physician" before further payments will be made.

NOTE: On the day the employee returns to work a "Return to Work Notice" should be completed by you and mailed direct to the Plan office.

Please note Weekly Indemnity benefits are not paid to employees who are on leave of absence for Compassionate, Educational or Training purposes or Extended Vacation. If disabled on the date the leave of absence expires, employees may receive benefits if they have returned to B.C. or if hospitalized in B.C. in a hospital recognized by the B.C. Medical Plan.

At any time, you as employer are entitled to contact the Plan Administration Office for information on the status of the claim, specifically, the expected return to work date.

WORKERS' COMPENSATION BOARD REIMBURSEMENT

1. If an employee is refused a Workers' Compensation Board benefit or if the Workers' Compensation Board is delayed, the employee may complete a Reimbursement Agreement and present a claim for Weekly Indemnity benefits.

   Note: A reimbursement agreement is not required if the employee is making a claim and is in receipt of a permanent partial disability

pension from the W.C.B. and is not appealing the decision of the W.C.B.

2. The Reimbursement Agreement is reviewed and signed by the employer and forwarded along with the Wage Indemnity claim form.

3. When the Wage Indemnity claim is approved and benefits paid, a copy of the Workers' Compensation Board Reimbursement Agreement is provided to Workers' Compensation Board so that any subsequent approval and payment for Wage Loss by the Workers' Compensation Board will be processed through Pacific Blue Cross.

4. When Pacific Blue Cross receives a Wage Loss benefit cheque from Workers' Compensation Board following a successful appeal, that cheque is payable to the employee.

   The back of the Workers' Compensation Board cheque is endorsed for deposit to the Southern Interior Health and Welfare Plan, and the Workers' Compensation Board cheque is accompanied by a Trust Fund cheque paying the employee the difference between the amount that is owed to the Health and Welfare Plan and the benefit paid by Workers' Compensation Board.

5. The employer will receive:

   - the Workers' Compensation Board Wage Loss cheque.
   - the Trust Fund cheque
   - a statement outlining the calculation and
   - a letter asking that the Workers' Compensation Board cheque is signed by the employee and returned to PBC, and that when the Workers' Compensation Board cheque is endorsed, the Trust fund cheque be given to the employee.

CANADA PENSION PLAN (CPP) DISABILITY BENEFITS

When an employee has been in receipt of WI benefits for 90 days, a copy of the Canada Pension Plan's "Disability Benefits" pamphlet, with a covering letter, is enclosed with his next cheque. Of course, not all disabled employees should apply for these benefits at that time. Only a small fraction of WI claimants reach 26 weeks on claim, and fewer still are permanently disabled.

However, if in the judgment of the employee and his physician the disability is severe and likely to be prolonged, an early application for CPP Disability Benefits may help to assure him of future income.

CPP Disability Benefits, payable to qualified employees from the fourth month after disability, do not reduce Weekly Indemnity payments, although

they are integrated with any LTD benefits the employee may later qualify for. In addition, receipt of CPP benefits while the employee is unable to work ensures the maintenance of eventual CPP Retirement Benefits.

If the employee wishes to apply for CPP Disability benefits, he must telephone to make an appointment at the nearest office of Health and Welfare Canada's Income Security Programs. Their number is in the blue pages of the telephone directory. If the disability prevents the employee from going in for an appointment, Health & Welfare Canada will arrange to go to the employee.

STATUTORY HOLIDAYS

On May 29, 1998, the IFLRA wrote to all Participating Employers announcing a method agreed to by the parties to avoid double payment for statutory holidays for employees returning from weekly indemnity (WI) within the 90 day qualification period (Article XII, Section 2(f)).

1) The WI benefit is paid for all days for which a claimant qualifies including any statutory holidays falling within the period of claim.
2) When an employee returns to work within 90 days of last day worked, the employer is required to pay the employee for any statutory holidays falling within the 90 day (or less) period.
3) The employer deducts the amount paid for each statutory holiday by the WI plan from the amount paid to the employee for the same day. The employer then reimburses the WI plan with the amount deducted, by including it with their next remittance to the Southern Interior Health & Welfare Plan.

The IFLRA prepared, and distributed to Participating Employers, a "Supplemental Payroll Form – Statutory Holidays", for this purpose.

Rate for 1998 to 2009 - At the time this agreement was reached, the amount for a statutory holiday paid for under the WI plan (the WI daily rate) was $449 per week, divided by 7, or $64.14.

NOTE that the new daily rate is only in effect for new disability claims on or after January 1 of each year.

Rates for 2013 – The weekly WI benefit increased to $501 per week for new claims beginning January 1, 2013 or later. Therefore the WI daily rate changed to $501 / 7 = $71.57.

Rates for 2014 – The weekly WI benefit increased to $614 per week for new claims beginning January 1, 2014 or later. Therefore the WI daily rate changed to $614 / 7 = $87.71.

Rates for 2015 – The weekly WI benefit increased to $624 per week for new claims beginning January 1, 2015 or later. Therefore the WI daily rate changed to $624 / 7 = $89.14.

GRADUATED RETURN TO WORK

The purpose of this voluntary program is to help disabled employees return to the jobs they held before becoming disabled.

It involves a return to work on a part-time basis when the member and the doctor agree that the member is ready. The employer, local union, disabled member and a rehabilitation counselor develop a modified work schedule which increases until the member can return to work full-time.

Normally a reduced number of hours is worked each day, but the agreed schedule may involve a reduced number of days each week, until the member is working full-time.

Disabled members who participate in the graduated return-to-work program continue to receive full WI benefits until the member's full time hours are reached. In addition, the employer tops-up the hourly wage up to the full rate.

FORMS-WEEKLY INDEMNITY CLAIM FORM

SOUTHERN INTERIOR HEALTH & WELFARE PLAN

Weekly Indemnity Benefits Claim

To avoid any delay in the processing of your claim, please be sure ALL questions are answered.

If printing this form from the internet, keep it clipped or stapled to ensure all 9 pages are submitted to Pacific Blue Cross.

NOTICE OF CLAIM must be given not later than 30 days following the first day of illness or accident and proof submitted within these 30 days.

NOTE:
A reimbursement agreement on a separate form provided by the plan must be completed in the case of claims where a full and proper WCB claim has been filed at least four weeks earlier and for which no decision has been reached or the claim disallowed.

Mailing Address:
Southern Interior Health & Welfare Plan
c/o Pacific Blue Cross
PO Box 7000
Vancouver, BC V6B 4E1

Telephone:
1 888 275-4672 *(toll free)*
604 419-8080

Fax:
604 419-8099

Administered under contract number 907704 by:
Pacific Blue Cross

0670.006.081—52-60-105 01/20 CLPE 1816

SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

1. PERSONAL INFORMATION

Name (first, middle, last) | ☐ Mr. ☐ Ms. ☐ Miss. ☐ Mrs.

Date of birth (mm-dd-yyyy) | Social Insurance Number | Local union number

Street address

City | Province | Postal code

Mailing address (if different from above) | Phone number

Do you want your cheque sent to the mailing address? ☐ Yes ☐ No

2. DISABILITY INFORMATION

When did your sickness begin or accident happen? Date (mm-dd-yyyy)

Date last worked Date (mm-dd-yyyy)

On what date did disability prevent you from working? Date (mm-dd-yyyy)

Have you ever had the same or similar illness? ☐ Yes ☐ No If yes, state when and describe Date (mm-dd-yyyy)

Is disability due to an injury? ☐ Yes ☐ No If yes, what kind of injury: ☐ MVA ☐ Work ☐ At home ☐ Other

Describe how and when the injury occurred Time _____ ☐ AM ☐ PM Date (mm-dd-yyyy)

Is there any third party legal action involved? ☐ Yes ☐ No If yes, please provide lawyers' name and address:

Legal representative's name: _____

Legal representative's address: _____

Note: Reimbursement Agreement and Direction on page 5 to be completed for all claims resulting from an accident where a third party is involved.

If injury at work, has a WCB claim been filed? ☐ Yes ☐ No WCB claim number Date claim filed (mm-dd-yyyy)

Has an appeal been filed? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Does this disability relate to a previous WCB claim? ☐ Yes ☐ No Date claim filed (mm-dd-yyyy)

Are you receiving WCB disability benefits? ☐ Yes ☐ No If yes, provide the frequency and amount of benefits.

Frequency of benefits: _____ Amount of benefits: $ _____

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

Have you been hospitalized for this sickness/injury? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: | Admission date (mm-dd-yyyy) | Discharge date (mm-dd-yyyy)

Did you visit the emergency room? ☐ Yes ☐ No
If yes, provide the hospital name, admission and discharge dates.

Name of hospital: | Admission date (mm-dd-yyyy) | Discharge date (mm-dd-yyyy)

Please provide the following information about the family doctor who has your **medical records**.

Last name of doctor	First name of doctor	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits
City	Province	Type of treatment received	
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)	

Please provide the following information about **any other specialist or health care practitioner** you have seen or are scheduled to see for this condition.

Last name of doctor	First name of doctor	Speciality	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)		
Last name of doctor	First name of doctor	Speciality	Date of first visit (mm-dd-yyyy)	Date of latest visit (mm-dd-yyyy)
Address of doctor (number and street)	Suite	Frequency of visits	Reason for visits	
City	Province	Type of treatment received		
Postal code	Telephone number	Date of next visit (mm-dd-yyyy)		

Have you been referred to a specialist? ☐ Yes ☐ No If yes, provide the name and date.

Name of specialist: | Date (mm-yy-ddd)

Have you returned to work? ☐ Yes ☐ No If yes, when? If no, when do you expect to return? | Date (mm-yy-ddd)

3. SUMMARY OF EDUCATION, TRAINING AND EXPERIENCE

School grade reached? Work experience?

Other training, upgrading, on-the-job training or special interests:

Does your job require a professional certificate, licence or other qualifications? ☐ Yes ☐ No
If yes, please describe:

Do you have a valid driver's licence? ☐ Yes ☐ No | Class | Restrictions

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYEE'S STATEMENT

I certify that the answers given are complete, current and accurate to the best of my knowledge and belief.

I agree to refund any monies which may be due to the Southern Interior Health & Welfare Plan c/o Pacific Blue Cross as a result of payment of disability benefits from any source in accordance with the provisions of the Southern Interior Health & Welfare Plan Text.

I authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, the Workers' Compensation Board of BC/Review Board/Medical Review Panel to release to Pacific Blue Cross, the Trustees of the Southern Interior Health & Welfare Plan, Evergreen Rehabilitation Management Society and the Trustees of the IWA-Forest Industry LTD Plan, any medical or benefit payment information, or any other information or records that may be requested by Pacific Blue Cross to establish or review the validity of this claim for Weekly Indemnity benefits for the period commencing (mm-dd-yyyy): _____

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information regarding the duties and requirements of my job to establish or review the validity of this claim for Weekly Indemnity benefits.

I authorize the Southern Interior Health & Welfare Plan, its Agents and my Employer to exchange information required to develop a Recovery Plan and/or Return to Work Program.

I authorize the Southern Interior Health & Welfare Plan and its Agents to release to my employer information regarding my expected return to work.

I authorize the use of my Social Insurance Number for the purpose of tax reporting and for the identification and administration of my Group Benefits.

I understand the Weekly Indemnity benefit will be reduced by Income Tax withholding as required by CRA.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge I must notify Pacific Blue Cross, as the agent of the Southern Interior Health & Welfare Plan, immediately should:

a) My medical condition improve so that I would be able to work, even though I have not yet returned to work,
b) I go to work whether as an employee or as a self employed person,
c) I apply for benefits under any Workers' Compensation law or plan,
d) I apply for benefits under Canada/Quebec Pension Plan,
e) I am discharged from hospital if I am hospitalized,
f) I return to work or receive any benefits/income related to my disability,
g) I apply for benefits from the IWA-Forest Industry Pension Plan.

Employee's signature X		Date signed (mm-dd-yyyy)
Employee's name (please print)	Policy number 907704	Certificate number/member ID

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5. REIMBURSEMENT AGREEMENT AND DIRECTION

Re: Group Contract No. 907704 between:
THE TRUSTEES OF THE SOUTHERN INTERIOR HEALTH & WELFARE PLAN and

Member name

Address | Member ID number

PART 1 — DEFINITIONS

PLAN refers to the Southern Interior Health & Welfare Plan.
PACIFIC BLUE CROSS, as agent for the Trustees of the PLAN.
YOU, YOUR and the MEMBER refer to the member with whom this agreement is made.
ACCIDENT refers to the incident giving rise to your claim for benefits from the PLAN.
THIRD PARTY refers to any other person from whom you may be able to recover damages as a result of your accident.

PART 2 — THE CONTRACTUAL ARRANGEMENTS

You may have a right to recover damages from a THIRD PARTY as a result of your illness, injury or income loss which arose from an ACCIDENT which occurred on (mm-dd-yyyy): _____

Under the terms of the PLAN, you are entitled to claim Weekly Indemnity (WI) benefits in respect of some or all of the period you have been absent from work commencing (mm-dd-yyyy): _____

You agree to take all neccessary steps to recover from the THIRD PARTY the benefits which the PLAN has paid, or will in the future, pay to you. If you fail to take such steps you agree that PACIFIC BLUE CROSS may do so on your behalf, and you hereby assign to PACIFIC BLUE CROSS the right to do so in accordance with the terms of the PLAN.

If you are able to recover such benefits from a THIRD PARTY, you will repay the PLAN, c/o PACIFIC BLUE CROSS, in accordance with the terms of the PLAN. The following is a summary of the reimbursement formula:

Reimbursement Amount = (WI Benefits Paid + Gross Wage Loss Recovery) – (Lost Wages + Pro-rata Share for Legal Expenses);

- WI Benefits Paid is the amount of benefits actually paid to you up to your Settlement Date.
- Gross Wage Loss Recovery is the lesser of your Gross Settlement and your Lost Wages.
- Lost Wages is calculated by multiplying your regular job rate times 40 hours per week, times the number of weeks you receive WI benefits prior to your Settlement Date. Lost Wages will reflect scheduled increases in your hourly job rate during the disability period.
- The Pro-rata Share of Legal Expenses is your Legal Expenses multiplied by your Gross Wage Loss Recovery divided by your Gross Settlement (to a maximum of 20% of your Gross Wage Loss Recovery).
- For greater certainty, Legal Expenses includes legal fees, disbursements and all applicable taxes, including any GST or SST paid to your lawyer. In no event shall the amount allowed for the Pro-rata Share of Legal Expenses exceed 20% of your Gross Wage Loss Recovery. Disbursements and taxes paid on the legal fees are *included* in the 20% of Gross Wage Loss Recovery.

If you abandon or settle any claim you have against the THIRD PARTY without the written consent of PACIFIC BLUE CROSS, your Reimbursement Amount will equal the full amount of benefits received by you. In addition, if you wish PACIFIC BLUE CROSS to consider accepting less than full reimbursement of benefits paid, you will instruct any legal representative acting for you to give PACIFIC BLUE CROSS a full report of the details of any proposed settlement between you and the THIRD PARTY, for PACIFIC BLUE CROSS approval before any settlement is reached.

You hereby authorize and direct anyone (including ICBC) with knowledge of your ACCIDENT or any settlement relating to it to release to PACIFIC BLUE CROSS the details of any settlement you reach.

You agree to provide full details of any settlement to PACIFIC BLUE CROSS, and pay the Reimbursement Amount calculated above to PACIFIC BLUE CROSS as soon as you receive your settlement payment.

You hereby assign to PACIFIC BLUE CROSS all of your interest in any amount that is owing to you in respect of the ACCIDENT, up to the amount of the Reimbursement Amount calculated above. In particular, you irrevocably authorize, instruct and direct any legal representative who acts for you to pay PACIFIC BLUE CROSS the Reimbursement Amount out of any settlement payments received on your behalf.

The foregoing is a summary of the relevant terms of the PLAN. In the event of an inconsistency between this form and the PLAN, the PLAN prevails. You may obtain a copy of the relevant terms of the PLAN at any time at no charge.

PACIFIC BLUE CROSS, as agent for the Trustees of the Southern Interior Health & Welfare Plan (OFFICE USE ONLY) | Date (mm-dd-yyyy)

Member **X** | Witness **X**

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
EMPLOYER'S STATEMENT

1. EMPLOYER INFORMATION

Name		Division
Street address		
City	Province	Postal code
Contact name / Title	Phone number	Fax number

2. EMPLOYEE INFORMATION

Name (first, middle, last)	Social Insurance Number	Date of birth (mm-dd-yyyy)
Seniority date (mm-dd-yyyy)	Date last worked (mm-dd-yyyy)	

Job Classification: attach job description and physical requirements

At the beginning of absence, the employee was:

☐ A regular full-time employee — For those employees working alternative shifts, please check days off: ☐Sun ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat

☐ Is this employee on an alternate schedule? ☐Yes ☐No — If yes, provide details:

☐ A regular laid-off employee — Date lay-off commenced (mm-dd-yyyy)

When laid off, this employee was entitled to _____ months continuation of lay-off coverage.

☐ A designated part-time employee — Provide details

☐ On leave of absence — From date (mm-dd-yyyy) To date (mm-dd-yyyy) Reason for leave of absence

Is leave for extended vacation or training other than apprenticeship training? ☐Yes ☐No

☐ On vacation with pay — From date (mm-dd-yyyy) To date (mm-dd-yyyy)

Is this claim one which might come under the Workers' Compensation act? ☐Yes ☐No
If yes, please submit copies of relevant WCB letters or correspondence.

Has employee returned to work? ☐Yes ☐No If yes, provide date of return — Date (mm-dd-yyyy)

Has employee claimed weekly indemnity benefits during the previous 4 weeks? ☐Yes ☐No

Have you any reason to question the validity of this claim? ☐Yes ☐No If yes, state reason:

_____

Who is the company contact for return-to-work issues? — Contact name — Phone number

Do you have a transitional work program or disability management program? ☐Yes ☐No If yes, describe:

_____

Is modified work available? ☐Yes ☐No If yes, describe:

_____

3. SIGNATURE

I certify that the above statements are correct.

Signed for employer by	Date signed (mm-dd-yyyy)
X	

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is claiming disability benefits from Southern Interior Health & Welfare Plan. As an initial step in the entitlement process, we ask that you complete this form, providing sufficient clinical information to enable us to make an informed decision. Incomplete information may delay the payment of your patient's claim.

Instructions:

1. Please PRINT.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

1. PATIENT AUTHORIZATION

Name	Policy number	Certificate number/Member ID
	907704	

I hereby authorize the release, to Pacific Blue Cross and Evergreen Rehabilitation Management Society, of any medical information, including copies of consultation and/or office notes and test/investigative reports, with respect to this claim for the period commencing (mm-dd-yyyy): _____

Patient's signature	Date signed (mm-dd-yyyy)
X	

2. ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS

Primary Diagnosis: _____

Secondary diagnoses or complications:

_____

Please describe any functional impairment or restrictions for your patient's ability to work:

_____

_____

Are these ☐ temporary or ☐ permanent? If temporary, expected duration: From (mm-dd-yyyy) To (mm-dd-yyyy)

CLINICAL INFORMATION

What date did symptoms first appear/accident happen? Date (mm-dd-yyyy)

How long has your patient had this condition? _____

Condition is due to ☐ Illness ☐ Injury ☐ Work-related ☐ MVA ☐ Other (specify below):

_____

What are your patient's current symptoms? _____

What are your clinical findings? _____

What are the dates of the first and latest visits for this condition? Date of first visit (mm-dd-yyyy) Date of latest visit (mm-dd-yyyy)

Dates of Visits (✔) exclusive of above procedures

PLACE	MONTH	YEAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OFFICE																																	
HOSPITAL																																	

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Your patient is: ☐ Ambulatory ☐ Bed confined ☐ Home confined
☐ Ambulatory with assistive devices ☐ Hospital confined

What is your patient's current height/weight/dominant hand? Current height Current weight Dominant hand ☐ Left ☐ Right

If patient is hypertensive, provide the last 3 blood pressure readings:

Reading: ____ Date (mm-dd-yyyy)	Reading: ____ Date (mm-dd-yyyy)	Reading: ____ Date (mm-dd-yyyy)

If psychiatric disorder, provide current GAF Score: _____

If cardiac disorder, provide American Heart Association Functional Classification: ☐ Class I (No limitation)
☐ Class II (Slight limitation) ☐ Class III (Marked limitation) ☐ Class IV (Complete limitation)

DIAGNOSTIC INVESTIGATIONS

Please enclose copies of current consultation and diagnostic investigative reports (X-rays, scans, laboratory data, etc.)

TREATMENT

Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN OR TO BE SEEN
		(mm-dd-yyyy)
		(mm-dd-yyyy)

Current medications:

NAME	DOSAGE	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Other forms of treatment or therapies:

TYPE	EXPECTED DURATION	WHEN STARTED	RESPONSE
		(mm-dd-yyyy)	
		(mm-dd-yyyy)	

Hospitalizations:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

Emergency Room treatment:

ADMISSION DATES	DISCHARGE DATES	FACILITY	REASON (DATE OF SURGERY IF APPLICABLE)
(mm-dd-yyyy)	(mm-dd-yyyy)		
(mm-dd-yyyy)	(mm-dd-yyyy)		

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SOUTHERN INTERIOR HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S STATEMENT

Treatment Response ☐ Recovered ☐ Improved ☐ No Change ☐ Retrogressed Comments:

Is your patient following the recommended treatment program? ☐ Yes ☐ No If no, please elaborate:

Details of any **proposed** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

LICENCE RESTRICTION

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition? ☐ Yes ☐ No

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification? Date (mm-dd-yyyy)

Would your patient be a suitable candidate for:

Vocational Rehab Program? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Modified work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Work hardening? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

Graduated return to work? ☐ Yes ☐ No If yes, when? Date (mm-dd-yyyy)

To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition. From (mm-dd-yyyy) To (mm-dd-yyyy)

If still unable to work, give approximate date patient should be able to return to work. Date (mm-dd-yyyy) or Estimated number of weeks before possible return to work

REMARKS

Please include any additional comments/information that you believe may help in the assessment of this claim:

3. SIGNATURE

Name of attending physician (please print)	Specialty	Phone number
Address (number, street, city, province, postal code)		Fax number
Signature X		Date signed (mm-dd-yyyy)

Page 9 of 9

FORMS – RETURN TO WORK NOTICE

Trustees of the Southern Interior Health & Welfare Plan

Return to Work Notice

Return completed form to:

Southern Interior Health and Welfare Plan
c/o Pacific Blue Cross
PO Box 7000
Vancouver BC V6B 4E1
Phone: 1-888-275-4672 | 604-419-8080
Fax: 604-419-8099

Instructions: For any employee who has been receiving Wage Indemnity Benefits, complete this form the day he returns to work.

POLICY#: 907704 MEMBER ID: _____

EMPLOYEE NAME: _____

DATE RETURNED TO WORK: _____
Month Day Year

If employee was able to return to work at an earlier date but did not return because of a lack of work, give full details.

.....

.....

.....

.....

EMPLOYER: _____

BY: _____

DATE: _____
Month Day Year

B. WAIVER OF PREMIUM

(Continuation of Group Life Insurance while disabled)

If

- upon expiration of Weekly Indemnity Benefits (26 weeks) or
- upon expiration of WCB Wage Loss benefits at the time a total and permanent disability pension is granted by the Workers' Compensation Board, or
- after 52 weeks of WCB Wage Loss benefits have been paid

the employee remains totally disabled, premiums are no longer required from the company. It is important that you identify your reasons for terminating premiums.

The member could then be entitled to Continuation of Group Life Insurance to age 65 without payment of premiums, so long as he remains totally disabled. The Plan Office will arrange this, contacting the member for information if necessary.

LTD claimants remain covered automatically. Retiring LTD claimants between the ages of 60 and 65 may be covered. Totally and permanently disabled members whose date of disability is prior to December 11, 1983 may remain covered for life. For other members, coverage ceases at age 65.

C. DEATH BENEFIT

1) Preliminary Notification of Death (Form GLM 698)

The employer should complete this report in duplicate as soon as practical and forward both copies to the Administrator.

This allows the plan office to review its records and advise the employer regarding the information required by the insurance company to prove the claim. In addition, this document constitutes part of the documentation required by the AD&D carrier.

The Administrator will provide you with all necessary claim forms.

NOTE: You may wish to notify the Administrator of the death by telephone prior to mailing the Notification. If you do so, it will expedite preparation of the forms.

2) The normal documentation requirements are as

follows: a) ALL DEATH CLAIMS

i) Death Certificate or Funeral Parlour Certificate. A photocopy is sufficient.

ii) Completed proof of Death, fully completed by the Employer and the Beneficiary. When the insurance is payable to a named beneficiary, the life insurance company can, immediately after it receives the Proof of Claim form, pay $5,000 to a spouse or $2,500 to any other named beneficiary.

b) ACCIDENTAL DEATH/SUICIDE

Additional information is required for death claims resulting from accidental death or suicide.

iii) Newspaper clipping and/or police report (where available).

iv) Coroner's Report - The Plan office provides a form letter to assist the family in obtaining this document.

v) Autopsy report

Where additional benefit may be payable under the Accidental Death provisions, additional forms must be completed. See section IX-D.

c) DEATH CLAIMS PAYABLE TO ESTATE

If the Estate has been named the beneficiary, if no beneficiary has been named, or if the named beneficiary has died and no new beneficiary was named, the insurance will be paid to the Estate. In such cases, the following additional documents are required:

vi) Probated Last Will and Testament

vii) Letters of Administration

d) DEATH CLAIMS PAYABLE TO MINOR

The following information is required when the named beneficiary has not attained age 18:

viii) Name of guardian, and their relationship to the child.

ix) Address at which the child resides, and with whom.

x) Copy of child's birth or baptismal certificate.

Should the beneficiary be under 18 years of age the benefit can be handled in the following ways:

a) If a Trustee is named on the beneficiary designation, the proceeds can be paid into a Trust account established by the Trustee.

b) The money can be held in Trust by the insurance carrier until the beneficiary reaches his 18th birthday, during which time interest accrues.

e) The money can be paid to a guardian or executor of the estate to be used for the beneficiary, in which case a notarized copy of Letters of Guardianship will be required.

FORM-PRELIMINARY NOTIFICATION OF DEATH

Southern Interior Health & Welfare Plan
c/o Pacific Blue Cross*
PO Box 24715, Stn. F, Vancouver, BC V5N 5T8
☎: 604 419-2481 FAX: 604 419-2884 Email: admn@pac.bluecross.ca Web: http://siw.planoffice.ca/

Please mail, fax or email this form immediately to the Southern Interior Health & Welfare Plan (i.e: prior to submitting proofs of Death claim form). *Note contact information above.*

PRELIMINARY NOTIFICATION OF DEATH (GLM 698)

Employer Name _____

Division _____

Name of Deceased _____

Social Insurance Number _____

Member's Address _____

Job Title _____

Date Last Worked _____

Date of Death _____

Cause of Death _____

Designated Beneficiary _____

Relationship to Beneficiary _____

Date _____ Employer Signature _____

When a claim is to be made for this benefit the following forms are required. These are available from the Plan Office, and when complete should be mailed direct to the Administrator.

1) Statement of Employer/Policyholder, Accidental Death or Dismemberment.

2) a) Statement of Beneficiary for Accidental Death, or

b) Statement of Claimant for Eye Loss, or

c) Statement of Claimant for Limb Loss

3) a) Statement of Attending Physician (Accidental Death claim)

b) Statement of Attending Physician (eye loss)

c) Statement of Attending Physician (limb loss)

d) Statement of Attending Physician, Loss of Use

4) Statement of Eye Witness

For further information on the Plan please refer to the Text of the Plan or contact your Head Office or the Administrator. Remember, the Accidental Death benefit is not paid in cases of suicide.

ACCIDENTAL DEATH OR DISMEMBERMENT
CLAIM FORMS WILL BE PROVIDED ON REQUEST

FORM - ACCIDENTAL DEATH REQUEST FOR CORONER'S REPORT

Chief Coroner for British Columbia
4595 Canada Way,
Burnaby, B.C.
V5G 4L9

Attention: Mr. R.W. Galbraith

SOUTHERN INTERIOR HEALTH AND WELFARE PLAN ADMINISTRATION MANUAL

Dear Sir,

! _____ (name), _____ (relationship) of _____ (deceased name) who died on _____ (date of death) at _____ (location) request a copy of the autopsy report and the coroner's findings of facts and any other examinations or analysis carried be sent to me to be used in the adjudication of an insurance claim with _____

Yours truly,
Signature
(Address)

E. EXTENDED HEALTH CARE

When a claim is being made for this benefit the employee must complete a claim form and mail it to the Plan Office along with the receipts.

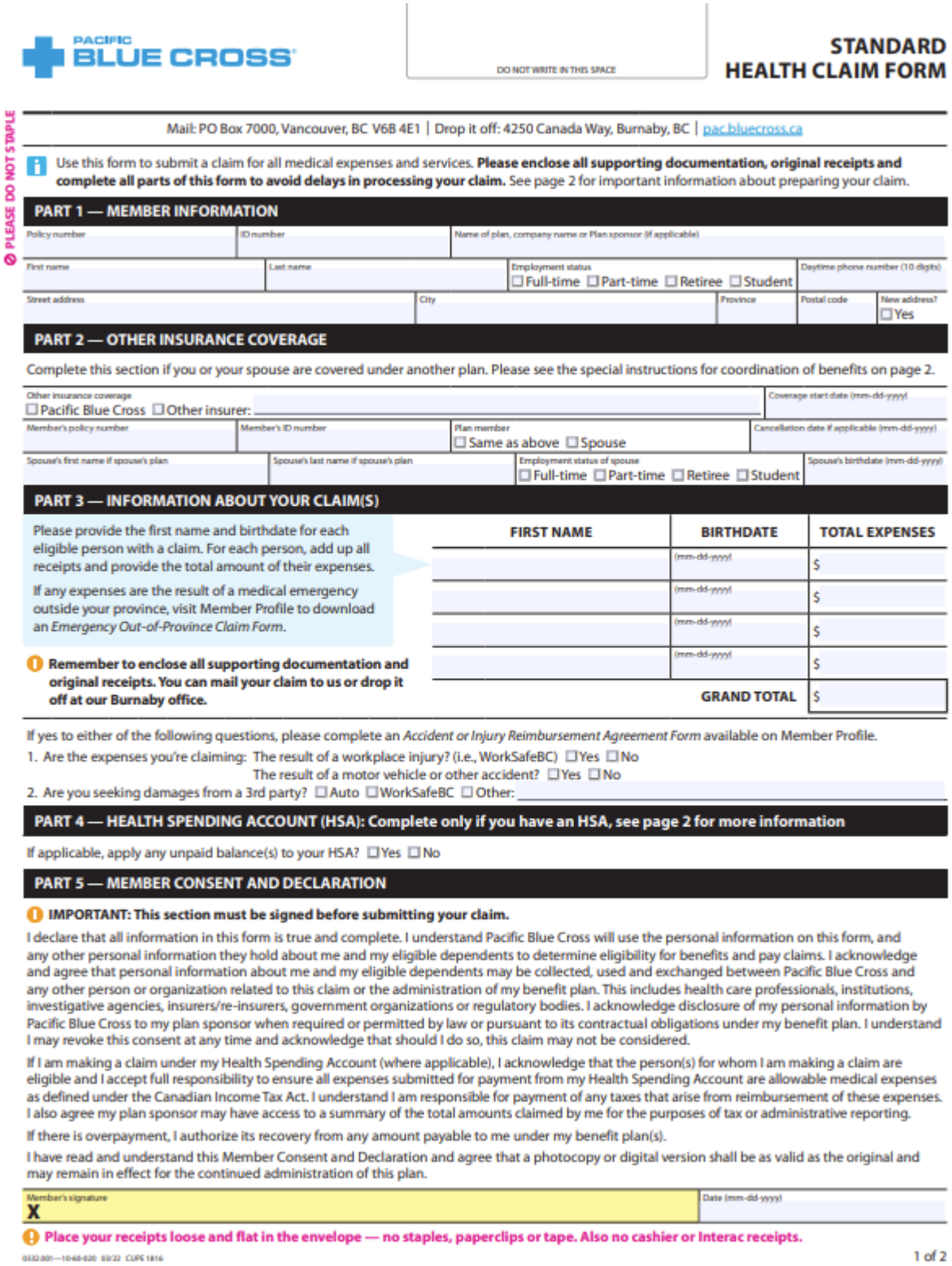
PHARMACARE

For a more complete description of Pharmacare please refer to the Plan booklet.

MEDICAL TRAVEL ALLOWANCE

For a more complete description of Medical Travel Allowance, please refer to the Plan booklet.

FORM – HEALTH CLAIM FORM



PACIFIC BLUE CROSS

DO NOT WRITE IN THIS SPACE

STANDARD HEALTH CLAIM FORM

PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

Use this form to submit a claim for all medical expenses and services. **Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim.** See page 2 for important information about preparing your claim.

PART 1 — MEMBER INFORMATION

Policy number | ID number | Name of plan, company name or Plan sponsor (if applicable)

First name | Last name | Employment status ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student | Daytime phone number (10 digits)

Street address | City | Province | Postal code | New address? ☐ Yes

PART 2 — OTHER INSURANCE COVERAGE

Complete this section if you or your spouse are covered under another plan. Please see the special instructions for coordination of benefits on page 2.

Other insurance coverage ☐ Pacific Blue Cross ☐ Other insurer: _____ | Coverage start date (mm-dd-yyyy)

Member's policy number | Member's ID number | Plan member ☐ Same as above ☐ Spouse | Cancellation date if applicable (mm-dd-yyyy)

Spouse's first name if spouse's plan | Spouse's last name if spouse's plan | Employment status of spouse ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student | Spouse's birthdate (mm-dd-yyyy)

PART 3 — INFORMATION ABOUT YOUR CLAIM(S)

Please provide the first name and birthdate for each eligible person with a claim. For each person, add up all receipts and provide the total amount of their expenses.

If any expenses are the result of a medical emergency outside your province, visit Member Profile to download an *Emergency Out-of-Province Claim Form*.

Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	GRAND TOTAL	$

If yes to either of the following questions, please complete an *Accident or Injury Reimbursement Agreement Form* available on Member Profile.

1. Are the expenses you're claiming: The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☐ No
   The result of a motor vehicle or other accident? ☐ Yes ☐ No
2. Are you seeking damages from a 3rd party? ☐ Auto ☐ WorkSafeBC ☐ Other: _____

PART 4 — HEALTH SPENDING ACCOUNT (HSA): Complete only if you have an HSA, see page 2 for more information

If applicable, apply any unpaid balance(s) to your HSA? ☐ Yes ☐ No

PART 5 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your claim.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims. I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If I am making a claim under my Health Spending Account (where applicable), I acknowledge that the person(s) for whom I am making a claim are eligible and I accept full responsibility to ensure all expenses submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Income Tax Act. I understand I am responsible for payment of any taxes that arise from reimbursement of these expenses. I also agree my plan sponsor may have access to a summary of the total amounts claimed by me for the purposes of tax or administrative reporting.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

Member's signature X | Date (mm-dd-yyyy)

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

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FORM - MEDICAL TRAVEL ALLOWANCE

Southern Interior Health & Welfare Plan
Medical Travel Allowance Referral and Claim Form

Return completed form to: **Southern Interior Health and Welfare Plan, c/o Pacific Blue Cross***
Priority Mailing Address: **PO Box 7000, VANCOUVER BC V6B 4E1**
Tel: 1 - 888 - 275 - 4672 ● 604 - 419 - 2600

PART 1 - TO BE COMPLETED BY EMPLOYEE **ENCLOSE ALL ORIGINAL RECEIPTS**

Company Name & Address

Member's Name
(Last) _____
(First) _____

Address
_____
_____
_____
Phone # _____

Group Number

Member's Identity Number

Patient's Name (Last) _____ (First) _____

Dependent Number _____ Date of Birth _____ D/M/Y

CLAIM FOR TRAVEL EXPENSES (Airfare, etc. - in the case of automobile, please show mileage x 30¢/km.)

From	To	Amount Claimed

CLAIM FOR ACCOMMODATION EXPENSES (You must provide receipts for all accommodation expenses)

Name of Accommodation	Location	# Days	Amount Claimed

Total Amount Claimed _____

PART 2 - REFERRAL (MEDICAL SPECIALIST) TO BE COMPLETED BY REFERRING PHYSICIAN

Patient's Name _____

Location _____

Reason for Referral _____

Referred to Medical Specialist (** see Part 3)
Dr. _____
Specialty: _____

Referral Date _____ D/M/Y
Appointment Date _____ D/M/Y

Attendant/Escort required: Yes ☐ No ☐

Reason(s) Attendant/Escort required: _____

If there is more than 2 months between the referral date and appointment date please explain why: _____

Reason for referral outside Regional Services Area: Services not available ☐ To expedite services ☐ Physician Preference ☐
Other Reason: _____

Referring Physician's signature: _____ Date: _____

PART 3 - TO BE COMPLETED BY THE MEDICAL SPECIALIST specified in Part 2**

I confirm that the above noted patient has attended the appointment as referred.

Specialist Physician signature: _____ Date: _____

I understand that expenses payable under the WCB Act or by MSP of BC, ICBC or other sources are not eligible for reimbursement and I certify that the reimbursement I am seeking is related to the medical appointment referred to above.

Member's signature: _____ Date: _____

See explanation of terms and conditions on back of form ...

*Pacific Blue Cross™, the registered trade name of PBC Health Benefits Society, is an independent licensee of the Canadian Association of Blue Cross Plans. \siwfmed.docx REVISED May 2014

F. DENTAL BENEFITS

Normally, the dentist submits the claim for Dental Services directly to the Plan. This is usually true even for dentists who require payment in advance from the member. However, if for any reason claim forms are required, or if assistance is required in their completion, please contact the Plan office.

NOTE: Remember that pre-authorization is required for Orthodontia, and recommended for other major expenses, as outlined in the Plan booklet.

NOTE: If an employee has refused to authorize the use of his Social Insurance Number for Plan administration, an alternative identification number will have been issued. It is the member's responsibility to ensure the dentist uses the correct identification number when submitting claims.

VIII. TAXATION

Tax Status of Plan Benefits

The premiums paid by the Plan on the members' behalf for Group Life insurance are a taxable benefit to the employee. The Plan office will notify you towards the end of each year of the monthly taxable benefit for the coming year. This is to allow your payroll system to accrue the taxable benefits for each employee for each covered month, for reporting on the T4 you issue each year-end.

The Basic Medical (MSP-BC) premiums you pay on an employees' behalf, which are not a part of this Plan, are also a taxable benefit and should also be included in the T4s.

STD benefits are also taxable income. Employees who receive STD Benefits in a year will receive a T4A from BC Life for those payments at year-end. If the employee later repays BC Life due to a successful WCB or third party (e.g. ICBC) claim, he or she will receive an adjustment letter for the repayment from BC Life.

Calculation of Taxable Benefits

You may notice that rate of Taxable Benefit for a year is different from the cost of Group Life Insurance in the breakdown of the monthly contribution rate.

This is because the Group Life Insurance portion of the monthly contribution is an ***estimate*** of the expected future cost of life insurance, based on the plan's demographics and past claims experience.

As is common with large groups, the financial arrangements with the insurance carrier are negotiated so that adjustments are made for actual experience. That helps us keep overall costs as low as possible by essentially sharing the risk with the insurance carrier.

In accordance with the tax regulations as they apply to this kind of plan, the amount of taxable benefit is calculated by applying the actual costs per employee for the most recent complete contract year to the benefit levels of the coming year. This means that depending on the number of deaths in the past year, the taxable benefit for the coming year can change significantly even though there is little or no change in the monthly contribution rate.