SOUTHERN INTERIOR HEALTH & WELFARE PLAN

REIMBURSEMENT AGREEMENT

EMPLOYER STATEMENT

British Columbia Life & Casualty Company (BC Life) is hereby requested to pay Weekly Indemnity benefits under the terms of the Southern Interior Health & Welfare Plan to:

Employee name: _____ Certificate number: _____ on account of a period of disability which the employee contends commenced on _____ , 20 ____, on condition that the employee agrees to reimburse BC Life to the extent that any Workers' Compensation Board (WCB) benefits received duplicate such Weekly Indemnity payments or are received with respect to the same period of disability, as specified in the Plan text.

We certify that a full and proper claim was filed with WCB with respect to the above-mentioned disability at least four weeks ago on behalf of the above-mentioned employee, and that no decision has been reached concerning the member's claim, or the claim has been disallowed and an appeal of that decision has been filed (an appeal is not necessary if the employee's physician confirms that the cause and nature of the disability is non-occupational).

We undertake to inform BC Life, in writing, of the WCB decision in this matter as soon as such a decision is made known to us.

Employer name: _____ Signature of Official Representative: _____

Division: _____ Title: _____

WCB claim number: _____ Dated: _____

EMPLOYEE STATEMENT

With respect to my period of total disability which commenced on _____ , 20 ____, I declare that I have made a full and proper claim to WCB and that such claim requires further consideration by the Board with respect to that claim, or my WCB claim has been disallowed and, if appropriate under the terms of the Plan text, I have filed an appeal of that decision.

Pending payment in respect of my claim, I request that BC Life pay Weekly Indemnity benefits to me for the above-mentioned period of disability in accordance with the terms of the Plan text.

In consideration for the above, I hereby agree and undertake that, should such claim result in any payment being made to me by WCB for the same period of disability, I will refund BC Life the full amount (or less if the WCB payment is a lower amount) paid to me under this Agreement immediately upon receipt of such payment. In this regard, in accordance with WCB Policy 48.20, I authorize WCB to mail cheques payable to me for the disability period that commenced on the above date, in care of BC Life, PO Box 7000, Vancouver, BC, V6B 4E1.

Pursuant to the provisions of the applicable provincial and federal privacy legislation, I authorize WCB to release to BC Life the status of my claim and all details of the settlement, including the amount of money awarded to me for my claim, and the date(s) such money was awarded. I agree that BC Life may also release to WCB information directly related to the settlement of my claim and calculation of amounts repayable to the Plan. BC Life will use this information solely for calculating the balances repayable for my claim.

I have read, understood and agree to the above.

Signature of employee: _____ Signature of witness: _____

Dated: _____ Dated: _____

Address: Witness name/address:

_____ _____

Please retain copies of the completed form for the employer and the disabled employee, and send **the original** to BC life.