Bricklayers & Allied Craftworkers Pension Fund of AB & SK
CRA Registration No. 0584888

Claimant's Statement for Disability Pension

Please read all questions and print all answers. Mail the completed application and supporting documents to the fund office at the address at the end of this form. Please note, this form must be sworn before a Commissioner for Oaths.

Member Information					
Name (Last)	(First)	(Middle)		Sex	
				M	F
Address (Street)			Social Insurance Number		
City	Province	Postal Code	Telephone Number		

Member Statements		
Have you applied for Canada Pension Plan disability benefits?	Yes	No
Are you receiving Canada Pension Plan disability benefits?	Yes	No
If you have not applied or have been rejected for Canada Pension Plan (CPP) disability benefits, please indicate the reason. (The CPP may be consulted for confirmation.) Please note, eligibility for CPP disability benefits does not automatically entitle you to disability benefit from the Bricklayers & Allied Craftworkers Pension Fund.		
Have you applied for any other disability benefits (i.e. Workers' Compensation, Employment Insurance, private, or provincial)?	Yes	No
If you have not applied or have been rejected for any applicable disability benefits, please indicate the reason.		
If you are applying more than 6 months after the date you became disabled, indicated the reason for the delay.		
Are you currently employed?	Yes	No
Are you currently seeking employment?	Yes	No
If yes, indicate what kind of employment. Please note, verification from your annual Income Tax Return may be required.		

COMPLETE REVERSE SIDE AS WELL

Member Declaration

I hereby apply for a disability pension from the Bricklayers & Allied Craftworkers Pension Fund. The above statements are complete, true, and correctly recorded to the best of my knowledge and belief. I understand a false, misleading or inaccurate statement shall be sufficient reason for the denial, suspension or discontinuance of benefits under the pension plan and the Trustees shall have the right to recover any payments made to me because of a false, misleading or inaccurate statement.

I understand, to be eligible to receive a disability pension from the Bricklayers & Allied Craftworkers Pension Fund, I must be totally unable, whether from mental or physically disability, to perform the duties of any occupation for remuneration or profit, and such disability must be permanent and continuous for the remainder of my life, as per the Rules and Regulations of the Bricklayers & Allied Craftworkers Pension Fund.

I expressly consent, authorize, and direct every physician, surgeon or any other person who has examined me, every hospital or other institution in which I have received treatment, and every other plan, including the Workers' Compensation Board, to which I have applied, to disclose to the Bricklayers & Allied Craftworkers Pension Fund, any knowledge or information thereby acquired.

I understand, I may be required to provide, upon request of the Bricklayers & Allied Craftworkers Pension Fund, a complete copy of my latest annual Income Tax Return to verify I continue to meet the criteria to be eligible for receipt of a disability pension. Further, if I do not provide a copy of my latest annual Income Tax Return and the Notice of Assessment from Canada Revenue Agency, and such other reasonable information as may be required, the Bricklayers & Allied Craftworkers Pension Fund may suspend the payment of further disability pension payments to me.

I make this application and declaration conscientiously believing it to be true and knowing it is of the same force and effect as if made under oath and by virtue of the Canada Evidence Act.

DECLARED BEFORE ME in the _____)

of _____ , in the Province)

of _____ , this _____ day)

of _____ , 20 _____)
)
_____)
A COMMISSIONER FOR OATHS in and)
for the Province of _____)

_____
Member's Signature

_____
Name of Commissioner (Please Print)

_____
Expiry Date of Commissioner

You will be notified in writing of the decision made by the Board of Trustees regarding your application or if any additional information is required.

Please return this form, with your original signature by mail to:	Funds Administrative Service 10154 108 Street NW Edmonton AB T5J 1L3 Phone: (780) 452-5161 Toll Free: 1-800-770-2998

This personal information is being collected under the authority of the Bricklayers & Allied Craftworkers Pension Fund and will be used for the purpose of administering the pension plan. It is protected by the privacy provisions of the *Freedom of Information and Protection of Privacy Act.*

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Consent and Authorization to Release Information

I,_____, S.I.N. _____

the undersigned, having presented myself as a member of the Bricklayers & Allied Craftworkers Pension Fund of Alberta and Saskatchewan, hereby authorize you to release all information which you have in your possession relating to the rights and benefits under which I may have had as a member of this pension plan to _____. This Consent and Authorization will remain in effect until I notify you in writing that I am revoking this Consent and Authorization. This will accordingly be your good and sufficient authority to provide and release such information.

_____
Signature of Member

_____
Date

Please return this form, with your original signature by mail to:	Funds Administrative Service 10154 108 Street NW Edmonton AB T5J 1L3 Phone: (780) 452-5161 Toll Free: 1-800-770-2998

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Medical Report for Disability Pension

Please read all questions and print all answers. Please provide details in layman's terms whenever possible. Incomplete or illegible information may result in the rejection of the applicant's claim. A further independent medical examination and/or annual review may be required.

Mail the completed report and supporting medical documentation which may be relevant to the fund office at the address at the end of this form.

Any fees applicable for the completion of this form are the responsibility of the applicant.

Member Information		
Name (Last)	(First)	Social Insurance Number

Physician Statements					
The member is requesting, or is receiving, a disability pension from the Bricklayers & Allied Craftworkers Pension Fund. To be eligible, the member must be totally unable, whether from mental or physical disability, to perform the duties of any occupation for remuneration or profit, and such disability must be permanent and continuous for the remainder of his life.					
Is the member totally and permanently disabled, as defined above?				Yes	No
If NO, date the member was no longer disabled.	Month	Day	Year		
If YES, date the member became totally disabled.	Month	Day	Year		
Date of first visit	Month	Day	Year		
Date of last visit	Month	Day	Year		
Does the member have regular visits?				Yes	No
If you were not the physician in attendance at the onset of disability, please advise how the date of disability was determined.					
Diagnosis					

COMPLETE REVERSE SIDE AS WELL

Please explain how the medical condition prevents the member from being able to work.
Describe any treatment programs already provided and the results obtained.
Outline if any other treatment options are available (i.e. surgery, exercise, physiotherapy, medication, diet) which may alleviate this condition.
Give particulars of all other medical practitioners consulted or to whom the applicant has been referred (i.e. other physicians, specialist, or therapists), the date of consultation, and the results obtained.

Certification

I, the undersigned, a medical doctor licensed to practice under the laws of the province of _____, certify the above information to be true based on my knowledge of the member.

Signature of Physician	Date
Name of Physician (please print)	Address
Telephone	City, Province, Postal Code

I hereby authorize my physician to release any relevant medical information to the Bricklayers & Allied Craftworkers Pension Fund.

Signature of Member	Date

You will be notified in writing if any additional information is required.

Please return this form, with your original signature by mail to:	Funds Administrative Service 10154 108 Street NW Edmonton AB T5J 1L3 Phone: (780) 452-5161 Toll Free: 1-800-770-2998

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Declaration RE: Marital Status of a Deceased Member

IN THE MATTER OF AN APPLICATION BEING MADE TO THE BRICKLAYERS & ALLIED CRAFTWORKERS PENSION FUND OF ALBERTA & SASKATCHEWAN

I, _____ of the City of _____, in the province

of _____, DO SOLEMNLY DECLARE THAT:

1. In connection with an application that I have made to the Bricklayers & Allied Craftworkers Pension Fund, which was signed by me on the _____ day of _____, 20____, I have represented to the plan that at the time of the Participant's death:

   ☐ I was the "Pension Partner" of the late _____; and our relationship commenced on the _____ day of _____, _____; or

   ☐ The late _____, to the best of my knowledge, did not have a "Pension Partner".

2. I understand that the definition of a "Pension Partner" as defined by the *Pension Benefits Act*, in the province of Saskatchewan "pension partner" (i.e. spouse or common-law partner) means, in relation to another person means:
   a. a person who is married to a member or former member; or
   b. if a member or former member is not married, a person with who the member or former member is cohabiting as spouses at the relevant time and who has been cohabiting continuously with the member or former member as his or her spouse for at least one year prior to the relevant time.

AND I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the Canada Evidence Act.

DECLARED BEFORE ME at the _____)

of _____ , in the Province)

of _____ , this _____ day)

of _____ , 20 __)

_____)
A COMMISSIONER FOR OATHS in and)
for the Province of _____)

_____
Applicant's Signature

_____
Name of Commissioner (Please Print)

_____
Expiry Date of Commissioner

Please return this form, with your original signature by mail to:	Funds Administrative Service 10154 108 Street NW Edmonton AB T5J 1L3 Phone: (780) 452-5161 Toll Free: 1-800-770-2998

Authorized Documents for Proof of Age

Listed in order of preference, these are the only acceptable forms of proof of age:

1. Birth Certificate
2. Passport
3. Citizen Certificate
4. Immigration Papers
5. Baptismal Certificate
6. Native / Metis Status Card
7. Military Identification / Documentation indicating your date of birth

Original documents are not required. **Please note a driver license is not acceptable**.

If you cannot provide a photocopy of any of the above documentation, please complete a Declaration Re: Proof of Age and submit it to our office along with two pieces of identification (i.e. driver license and health care) showing your date of birth.

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Electronic Deposit of Pension Payments

As a pensioner (or a beneficiary receiving payments), I authorize the fund to electronically deposit my pension payments directly into the bank account described below. I understand I can change this authorization by sending a written notice to the fund office. I also understand my death will end the automatic deposit of pension payments without otherwise affecting future payments to which my beneficiary may be entitled.

Name of Institution									
Address									
City			Province	Postal Code					
Name(s) of Account Holder(s)									
Account No.			Bank No.			Bank Transit No.			

*** Please attach a VOIDED cheque if funds are to be deposited into a chequing account.**

If you require assistance providing the required information with respect to your bank account, please contact your financial institution.

_____
Date

_____
Social Insurance Number

_____
Signature of Pensioner or Beneficiary receiving payments

Please return this form, with your original signature by mail to:	Funds Administrative Service 10154 108 Street NW Edmonton AB T5J 1L3 Phone: (780) 452-5161 Toll Free: 1-800-770-2998