



BOILERMAKERS' NATIONAL HEALTH AND WELFARE FUND (CANADA)

Benefit Administration Office: 45 McIntosh Drive, Markham, Ontario L3R 8C7
 Telephone Toronto Area: (905) 946-2530 Toll Free: 1-800-668-7547 Fax: (905) 946-2535
 email: questions@boilermakersbenefits.ca

HEALTH BENEFITS DIRECT DEPOSIT AND E-NOTIFICATION REQUEST

INITIAL REQUEST CHANGE REQUEST

MEMBER PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

CITY _____ PROVINCE _____ POSTAL CODE _____

SOCIAL INSURANCE NUMBER: _____
 (THE USE OF THIS IS PROTECTED BY THE PLAN'S PRIVACY POLICY)

REQUEST FOR DIRECT DEPOSIT OF BENEFITS

To request direct deposit or to modify your banking information, **PLEASE ENCLOSE A VOID CHEQUE** with this request AND complete the information below. In both cases, please sign the authorization.

DEPOSIT TO (NAME OF ~~CO-OP~~ BANK OR FINANCIAL INSTITUTION) _____
 The Plan cannot deposit funds to a financial institution/bank outside Canada.

ADDRESS OF BRANCH _____

Branch Number	Institution Number	Account Number

AUTHORIZATION:

As the beneficiary of Health benefits paid under my Health and Welfare Plan, I hereby authorize the Boilermakers' National Health and Welfare Fund (Canada) (the "Fund") to deposit these sums in my bank account, whose particulars appear above, and on the enclosed VOID cheque, until such time as I make a written request to the contrary. I understand that the Fund has no further obligation with regard to the benefits paid in accordance with this request. I also understand that the Fund can, without prior notice, terminate the direct deposit of benefits and issue a cheque to me. This authorization, which takes effect on date below, is valid for all other active bank accounts in this or any other financial institution that I may name in the future.

Date: (DD/MM/YYYY) _____

MEMBER'S SIGNATURE _____

REQUEST TO SUBSCRIBE TO E-NOTIFICATION RECEIVED FOR DIRECT DEPOSIT

Subscribing to e-notification means you will be notified by email of the status of your Health benefit.

To subscribe to e-notification or to change your email address, please complete the information below. Check off the ONE box that corresponds to the address where you want to receive email notifications. **SELECT ONLY ONE EMAIL ADDRESS**

<input type="checkbox"/>	Work	Email Address: _____
<input type="checkbox"/>	Home	Email Address: _____

Please mail completed Direct Deposit and E-Notification Request Form to the Benefit Administration Office in the enclosed postage paid envelope.

Privacy Statement: THE PLANS WILL COLLECT, MAINTAIN AND COMMUNICATE ONLY THE PERSONAL INFORMATION CONSIDERED NECESSARY FOR THE ADMINISTRATION OF THE PLAN. PERSONAL INFORMATION WILL BE PROTECTED PURSUANT TO THE RELEVANT LEGISLATION. THE PLAN MAY USE AND EXCHANGE INFORMATION WITH RELEVANT PERSONS OR ORGANIZATIONS (INSTITUTIONS, INVESTIGATIVE AGENCIES, THE UNION, TRUSTEES, INSURERS, RE-INSURERS, AUDITORS, REGULATORS) IN ORDER TO MANAGE THE PLAN AND ENTITLEMENT TO THE BENEFITS OF THE PLAN. QUESTIONS RELATED TO THE PRIVACY POLICY SHOULD BE DIRECTED TO THE BENEFIT ADMINISTRATION OFFICE.