NEW LOOK

NEW LOGO

NEW DESTINATION FOR
PLAN MEMBER INFORMATION

www.ihavebenefits.ca
WELCOME TO YOUR BENEFIT PLAN

This booklet describes your benefit coverage under the No Frills/UFCW Benefit Trust Fund (“the Fund”). The Board Of Trustees is pleased to sponsor this program, known as “the Plan”, available to part-time employees of No Frills stores who are members of UFCW Canada Local 1006A and other local unions as may be approved for participation.

Your coverage includes Life Insurance, Prescription Drugs, Vision Care, and Health and Dental Care benefits. The Life Insurance benefit is underwritten by Manulife Financial, under Group Contract Number 30402. All other benefits are reimbursed directly from the Fund.

The information contained in this booklet does not create or confer any contractual or other rights. All claims are considered and paid in accordance with official documentation. The Trustees reserve the full authority for final interpretation and adjudication and may, from time to time, amend the coverage.

Please submit all claims and direct all questions to the Office of the Administrator at the address below.

No Frills/UFCW Benefit Plan
Suite 110 - 61 International Blvd.
Toronto, Ontario, M9W 6K4
Telephone: (416) 674-3350
Toll Free: 1-800-461-4361

Please visit your plan website at www.ihavebenefits.ca where you will find a pdf version of this benefit booklet, and you can print off a claim form, an application for supplementary hours credit or read more about your coverage.
**FILL OUT A REGISTRATION CARD**

When you join the Plan you are required to complete and sign (in ink) a Registration Card and return it to the Office of the Administrator. Registration Cards are obtained from your Employer, Local Union, or by contacting the Administrator. If any part of the information on the Registration Card changes, please complete and submit another card to the Administrator as soon as possible.

**NAME A BENEFICIARY**

You may name a beneficiary(ies) as the recipient of your Member Life Insurance benefit. If at any time you want to change this, you must complete and remit a new Registration Card and send it to the Office of the Administrator. The change will take effect upon the date it is executed, according to provincial law, and without prejudice to the Plan for any payments made before such change is received at the Administrator’s Office.

*In the event that the Administrator does not receive a Beneficiary Designation, the Member Life Insurance benefit must be paid to the Member’s estate and may be subject to an otherwise avoidable probate fee.*

**DEPENDANT INFORMATION**

Prescription drug expenses and dental care expenses for your dependant children will be reimbursed. Therefore, be sure to include their information when you complete a Registration Card.

Details are outlined in the Health Care and Dental Care sections of this booklet.
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**ELIGIBILITY**

**HOW AND WHEN DO I HAVE BENEFITS?**

You can earn eligibility for benefit coverage if you are an active part-time employee of a No Frills store as defined in your Collective Agreement and a Member of a bargaining unit represented by UFCW Canada Local 1006A or another approved Local Union, with Contributions made continuously on your behalf by your Employer. You must also already be covered under a provincial health insurance plan.

Eligibility for benefit coverage is earned on a six-month basis. For example, to be eligible for coverage from January to June, you must have worked a minimum of 350 hours in the six-month period May to October of the preceding year.

To be eligible in each subsequent six-month period, the minimum hourly requirement (350 hours) must be attained during the period(s) November to April, and May to October.

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Your coverage will become effective on the date you become eligible and as long as Contributions continue to be submitted on your behalf. Coverage will also continue during an approved leave of absence due to illness, injury, maternity or parental leave provided you notify the Administrator of such leave.

**IS MY DEPENDANT CHILD COVERED FOR BENEFITS?**

Yes. Prescription drug expenses and dental care expenses for your dependant children will be reimbursed. Details are outlined in the Health Care and Dental Care sections of this booklet.

A dependant child is a natural or legally adopted child or a stepchild: under 19 years of age and living with you on a full-time basis; or, a disabled child 19 years of age or older if solely dependent on you for support.

**DO I HAVE BENEFIT COVERAGE WHILE COLLECTING WORKPLACE SAFETY AND INSURANCE BOARD ("WSIB") BENEFITS?**

If you are receiving WSIB loss of earnings benefits, coverage will be continued for up to 12 months.

**DO MY BENEFITS CONTINUE DURING A TEMPORARY ABSENCE FROM WORK?**

Your coverage will continue during a temporary absence for maternity or parental leave.
**WHAT IS A SUPPLEMENTARY HOURS CREDIT, AND HOW DOES IT WORK?**

If you are absent from work due to illness, injury, or jury duty and therefore cannot meet the minimum hourly requirement for benefit reimbursement (350 hours worked in a qualifying period), the Administrator, following receipt and approval of a complete application, will add the missing hours to your record.

Application forms can be obtained at ihavebenefits.ca or by contacting the Administrator at (416) 674-3350 or 1-800-461-4361.

For jury duty, you are eligible for up to 10 days at the average number of hours you worked, prior to your leave. Average hours are calculated based on your weekly hours in the 13 weeks immediately preceding your leave. The total will then be added to the hours worked in the related qualifying period.

The supplementary hours credit is also available if you are absent from work due to an illness or injury, and have been seen and treated by a licensed doctor (MD) and for Compassionate Care Leave to a maximum of 3 months. All sections of the application must be completed if the leave is due to illness or injury. The hours to be credited will be calculated in the manner as described above.

**WHEN DO MY BENEFITS TERMINATE?**

Your coverage will terminate when one of the following occurs:

- your employment terminates or you cease active work, unless you are on approved temporary absence from work due to illness, injury, pregnancy or parental leave or compassionate care leave, and provided the Administrator has been notified of such leave;
- you did not accumulate enough hours during a qualifying period;
- contributions and/or premium payments cease;
- you retire;
- you die; or
- this Plan is discontinued.

**WHAT IF I ALSO HAVE BENEFITS UNDER ANOTHER INSURANCE PLAN?**

If you have coverage under an insurance plan in addition to this one, you may coordinate your benefits so that you receive payments from both plans to cover charges. The amount you receive may not exceed 100% of the total allowable expense.

The first step is to determine which plan pays first (where to submit the claim first) and which plan pays next. The plan that does not have a coordination of benefits provision pays before the plan that does (generally all benefit plans do have a provision).

The plan that covers you as a primary recipient pays before the plan that covers you as a dependant.

If priority cannot be established this way, the benefits will be pro-rated between or amongst the plans in proportion to the amounts that would have been paid had there only been coverage by either one individually.
To implement this provision, the Administrator may:

- if required by law, and subject to the consent of the covered person, obtain from or release to any other person, corporation, or organization any information deemed to be needed; or

- pay to, or recover from, any other person, corporation, or organization any excess payment; any payment so made will be deemed to be benefits paid and, to the extent of such payments, will fully discharge the Fund from all liability under this plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

MEDICAL INFORMATION BUREAU (MIB)

MIB Group, Inc. (MIB) is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Manulife Financial or its re-insurers may periodically report information to the MIB. If you apply to receive life insurance coverage from another MIB member company or submit a claim for benefits to such a company, the MIB will, upon request, supply the other insurer with the information on file. Manulife Financial or its re-insurers may also release the information in its file to other life and health insurance companies to whom you may apply for insurance or submit a claim for benefits. All information obtained will be treated as confidential.

Upon your request, the MIB will arrange disclosure of any information you may have in your file. If you question the accuracy of the information in the MIB file, you may contact the MIB and seek a correction. Their address is:

Tel: (416) 587-0590.
**DO I HAVE A LIFE INSURANCE BENEFIT?**

**Yes.** All eligible, part-time, employees are entitled to a $10,000.00 Life Insurance benefit. This amount will be paid to your beneficiary(ies) if living, otherwise to your estate.

If you become Totally and Permanently Disabled while covered, and continue to be so disabled for the next 6 months, your Life Insurance will continue until your 65th birthday. You must submit proof satisfactory to Manulife Financial, within 12 months of the date you cease active work, that you are so disabled. Upon approval, you must submit proof satisfactory to Manulife Financial, as required, that you are still so disabled.

Totally and Permanently Disabled means that solely because of an illness or injury, you are, and will continue to be, unable to work at any occupation for which you are, or may reasonably become, fitted by education, training or experience.

**WHAT IS A CONVERSION OPTION AND HOW DOES IT WORK?**

If your Life Insurance terminates because:

- your employment terminates;
- you did not accumulate enough hours during a qualifying period;
- you no longer qualify for coverage under the Disability Provision; or
- this benefit is discontinued,

you are permitted, on or before your 65th birthday, to convert up to 100% of the terminated amount, less any amount of group life insurance for which you may become eligible within 31 days of the date of the termination.

You may convert to an individual:

- ordinary life plan then being issued by Manulife Financial;
- one-year convertible term insurance (if you have not passed your 65th birthday); or
- term insurance to age 65.

There is a limit on the amount which can be converted and it may include disability or other added benefits. You must apply in writing and pay the first premium to Manulife Financial within 31 days of the date your insurance terminates. The premium rates will be based on your age and class of risk at the time of conversion. No medical examination or health questionnaire will be required.

**EXTENSION OF BENEFIT**

If you die within 31 days of the date your Member Life Insurance terminates, the amount you could have converted will be paid as a death benefit under this plan even if you did not apply for conversion.
DO I HAVE HEALTH BENEFITS?

Yes, if you are an active part-time employee and fulfill all of the requirements for eligibility. All health care expenses are reimbursed at 80%, except where otherwise noted.

IS THERE A DEDUCTIBLE?

No. You are not required to pay a deductible.

WHAT IS COVERED UNDER MY HEALTH CARE BENEFITS?

Your Plan covers the following services and supplies for Members only.

Note: *Health Practitioners, Eye Exams, Hearing Aids, and Foot Care are subject to a Combined Benefit Maximum of $100.00 in each eligibility period.

HEALTH PRACTITIONERS*

Your Plan covers charges by registered and legally practicing Chiropractors, Chiropodists, Osteopaths, Naturopaths, Podiatrist and Physiotherapists at 80% to the Combined Benefit Maximum of $100.00 in each eligibility period.

EYE EXAM*

You are reimbursed for the cost of an eye exam at 80% up to the Combined Benefit Maximum of $100.00 in each eligibility period.

HEARING AIDS*

Hearing aids are covered at 80% up to the Combined Benefit Maximum of $100.00 in each eligibility period.

FOOT CARE*

Your Plan covers Orthopedic shoes or Orthotic devises at 80% up to the Combined Benefit Maximum of $100.00 in each eligibility period.
**DRUGS**

Prescription Drugs (GENERIC) are covered at 90% up to a Benefit Maximum of $10,000.00 per year once the $25 per family deductible has been satisfied. This applies to generic drugs only, (unless a physician specifically indicates that a brand name drug must be used), including oral contraceptives, obtainable only with a licensed doctor’s (M.D.) or licensed dentist’s prescription, and dispensed by a registered pharmacist. Viagra is covered at $1,000.00 per calendar year.

Prescription Drug (GENERIC) expenses for dependant children, incurred on or after September 1, 2007, will be reimbursed at 90%, to a maximum of $250.00 per dependant child, per calendar year once the $25 per family deductible has been satisfied.

**VISION CARE**  
For Members Only

Charges for lenses and frames, when prescribed by an ophthalmologist or optometrist, are covered at 100% up to a maximum of $150.00 in any 24-month period, or 12-month period if you are under age 18.

The cost of laser eye surgery, in lieu of lenses and frames, will be covered at the same amount. No amount will be paid for safety or sunglasses, anti-reflective coatings, or for tints other than No. 1 or No. 2.

**WHAT DOES MY HEALTH CARE COVERAGE NOT COVER?**

No amount is paid for care, services, or supplies:

- if the payment is prohibited by law;
- that a covered person may obtain as a benefit under any government plan or law;
- for which no charge would have been made in the absence of this coverage; or
- for dental work.

No amount will be paid for any charge that results from or is contributed to by:

- war, whether declared or not;
- insurrection, rebellion, or participation in a riot or civil commotion;
- a purposely self-inflicted injury; or
- from the covered person's commission of, or attempt to commit an assault or a criminal offence.
DO I HAVE DENTAL BENEFITS?

Yes, if you are an active part-time employee and fulfill all of the requirements for eligibility.

For all dental claims the current year’s Fee Guide (rotating on a yearly basis) published by the Ontario Dental Association (“ODA”), will be used by the Trustees to determine the amounts of benefit payment.

WHAT IS COVERED UNDER MY DENTAL CARE BENEFITS?

Your Plan covers the following services and supplies.

ROUTINE CARE

(Charges will be covered at 90% to a maximum of $750.00 every calendar year for all dental care combined for Plan Members).

For Members 18 years of age or younger Routine Care includes:

- oral exams, including the cleaning of teeth, but not more than once every 6 months;
- periodontal scaling and root planing (limited to 8 units per calendar year);
- topical application of sodium or stannous fluoride (where such application is necessary for the maintenance of sound dental health).

For Members 19 years of age or older Routine Care includes:

- oral exams, including the cleaning of teeth, but not more than once every 9 months;
- periodontal scaling and root planing (limited to 8 units per calendar year for all procedures combined).

For all Members:

- bitewing x-rays;
- fillings;
- extractions, including the extraction of impacted wisdom teeth;
- emergency treatment;
- antibiotic drug injections;
- anaesthesia;
- occlusal guards in connection with periodontal treatment for bruxism;
- periodontic treatment for disease of bone and gums of the mouth, including tissue grafts and occlusal guards, but not athletic guards; and
- endodontic treatment, including root canal therapy.

Dental expenses for dependant children will be reimbursed at 90%, to a maximum of $300.00 per dependant child, per calendar year.
**SHOULD I HAVE MY TREATMENT PRE-AUTHORIZED?**

If charges for a planned course of treatment by a licensed dentist are expected to exceed $300, proposed details and x-rays should be submitted to the Administrator for approval. Failure to do so may result in reimbursement of a lesser benefit amount because of the difficulty in determining the need for such treatment after it has been provided. Dental x-rays will be promptly returned to the dentist.

**OTHER PRACTITIONERS**

Services or supplies must be rendered and dispensed by a licensed dentist, except that scaling and cleaning of teeth may be done by a licensed dental hygienist.

Charges for such care, services, and supplies will be deemed to be Covered Charges up to the lesser of:

- the amount shown in the practitioner’s Fee Guide of the Province where the charges are incurred; or
- the fee guide for dentists.

**ALTERNATIVE SERVICES**

If alternative services are performed for the treatment of a dental condition, the maximum amount payable will be the amount shown in the Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

**WHAT DOES MY DENTAL CARE COVERAGE NOT COVER?**

No amount is paid for:

- dental care which is cosmetic;
- white fillings on molars;
- completion of claim forms;
- broken appointments;
- dental care covered under a medical plan provided by an employer or government;
- prefabricated full coverage restorations;
- oral hygiene instruction or nutritional counselling;
- protective athletic appliance;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- any services related to dentures, crowns, and bridgework;
- orthodontic treatment for correction of malocclusion.
NEED A CLAIM FORM?

HAVE A QUESTION ABOUT YOUR COVERAGE?

NEED TO CHECK THE RULES OF THE PLAN?

YOU CAN DOWNLOAD, DISCOVER, AND DETERMINE AT

www.ihavebenefits.ca
HOW DO I MAKE A CLAIM?

When you become eligible for coverage you will receive a "pay-direct" drug card, which is accepted for payment at most retail pharmacies. For all other claims, you can obtain a claim form from the Administrator, or print one off at www.ihavebenefits.ca. Be sure to complete it fully, attach original bills or receipts where applicable to substantiate it, and submit to:

No Frills/UFCW Benefit Plan  
Suite 110 - 61 International Blvd.  
Toronto, Ontario  M9W 6K4  
Phone: (416) 674-3350  
Toll Free: 1-800-461-4361

Note: Original documentation is required, therefore claims cannot be faxed. At the Administrator’s option, you may request in writing that all or part of the payment for Dental and Health Care benefits be paid directly to the person rendering such care. Original receipts will not be returned.

PROOF OF LOSS

LIFE INSURANCE - DISABILITY - HEALTH/DENTAL BENEFITS

Written proof stating the occurrence, character, and extent of loss must be submitted for each benefit to the Administrator within:

• 6 months after the date of death under the Death Provision for Life Insurance benefits;

• 12 months after the date the Member ceases active work because of Total and Permanent Disability under the Disability Provision for Life Insurance benefits; and

• 18 months after the date of the loss, but not more than 6 months after the date coverage terminates, for Health Care and Dental Care benefits.

Legal action to recover payments under this Plan must begin within 2 years (6 years for Life Insurance) of the date of loss. Manulife Financial shall have the right and opportunity to examine any person whose injury or illness is the basis of claim, when and as often as it may reasonably require during the pendency and payment period, if any, of such claim.

The benefits described under this Plan may be revised from time to time or discontinued. Detailed information about benefits or other provisions of the contract(s) or copies of those provisions may be obtained from the Administrator.
1. How do I know if I’m eligible to claim for benefits?
To be eligible in each 6-month period, you must have worked 350 hours in the prior six-month coverage period. For example, the first period is January 1 to June 30 and the second is July 1 to December 31st. Your coverage becomes effective once you have accumulated these hours, and so long as your Employer continues to contribute to the Plan on your behalf. You may contact the Administrator to determine whether or not you are eligible for coverage. Also, notices are sent out prior to the beginning of each 6 month period to inform you of your eligibility status.

2. What do my benefits cover?
- Health Benefits, including prescription drugs, health practitioners, eye exams, glasses, hearing aids and foot care
- Routine dental care benefits
- $10,000 of Life insurance

3. How do I claim?
For health and dental benefits fill out a claim form, available on the website or by request to the Administrator at (416) 674-3350 or toll free at 1-800-461-4361. When you filled out the form, you must attach the required documentation, (receipts, doctor’s diagnosis) originals only, and send it all to the Administrator’s office: No Frills/UFCW Benefit Plan Suite 110 - 61 International Blvd. Toronto, Ontario M9W 6K4
But not before making a copy for yourself. Don’t forget, this claim cannot be faxed and original receipts will not be returned.

4. Is there a limit to the number of covered visits I can make to the dentist?
In every calendar year there is a benefit maximum for routine dental care. For Members age 18 years and under your benefits cover one visit to the dentist every six months for oral exams and routine care. For members age 19 and over the benefit maximum covers one visit every 9 months.

5. How do I know if I’ve already reached my maximum for dental or health care?
A notice will be sent out with your benefit payment cheque when you have reached your maximum in a certain period. You can also call the Administrator’s office to enquire.
Telephone: (416) 674-3350 or toll free at 1-800-461-4361.

6. When does my coverage terminate?
Coverage ends when you are no longer working, (unless on an approved temporary leave), you did not accumulate enough hours during a qualifying period, or your Employer stops making contributions on your behalf, or the Plan is discontinued.

7. If I’m on a temporary leave from work, can I continue to accumulate hours for future eligibility?
Depending on the reason for your leave, missing hours will be added to your record. This is called the Supplementary Hours Credit, and it is based on the nature of your absence and the average number of hours you worked in the weeks prior to your leave. Application must be made to the Administrator for approval of such credit. Application forms can be obtained at ihavebenefits.ca or by contacting the Administrator’s office.

8. What is a beneficiary?
A beneficiary is the person you have chosen to receive your Life Insurance benefit if you die while covered by the Plan. When you first enroll in the Plan you are given a registration card to fill out. At this time you will indicate the name of your beneficiary. You can change this designated person as often as you wish, but you must do so by filling out an entirely new card and sending it to the Administrator’s office.

9. Can I be covered under this plan and another one at the same time?
Yes, you are allowed coverage under this Plan as well as another, and you can coordinate your benefits so that you receive reimbursement from both, so long as it does not total more than 100% of the cost of the service.

10. Is my child covered?
Yes. Prescription drug expenses and dental care expenses for your dependant children will be reimbursed. Details are outlined in the Health Care and Dental Care sections of this booklet.
GLOSSARY OF TERMS

ADMINISTRATOR
is the organization chosen by the Trustees to carry on the day-to-day business of the Fund and the Plan. Among its duties, the Administrator must answer questions from Members and process their claims for benefits.

BENEFIT(S)
means the amount of money that may be reimbursed to a Member toward the costs for a loss of life or for covered health or dental services and supplies.

BENEFIT MAXIMUM
is the total amount of benefit allotted for reimbursement in a calendar year or an eligibility period

CONTRIBUTIONS
means the amount of money that must be paid to the Fund, by the Participating Employer.

COURSE OF TREATMENT
means one or more services rendered by a dentist(s) for the correction of a dental condition, diagnosed in an oral exam. This treatment starts on the date the first corrective treatment is rendered.

COVERED CHARGES
are reasonable and customary charges for medical and dental care, services or supplies, received while the Member is covered.

DEPENDANT CHILD
A dependant child is a natural or legally adopted child or a step-child: under 19 years of age and living with you on a full-time basis; or, a disabled child 19 years of age or older if solely dependant on you for support.

LICENSED DENTIST
is a person licensed to legally practice dentistry in Canada.

LICENSED DOCTOR
is a medical doctor, (M.D.) legally practicing within the scope of his/her license.

MEMBER
means a person who is entitled to claim benefits by virtue of having satisfied the requirements for eligibility.

PERCENTAGE PAYABLE
is the portion of Covered Charges that the Plan pays.

PREDETERMINATION OF BENEFITS
is the proposed details and x-rays from a course of dental treatment that should be submitted to the Administrator for approval, especially for charges exceeding $300.00.

REASONABLE AND CUSTOMARY CHARGES
means any necessary charge connected to health and dental care that is deemed appropriate in relation to a loss and is financially acceptable.

TOTALLY AND PERMANENTLY DISABLED
means that solely because of an illness or injury you are, and will continue to be unable to work at any occupation for which you are, or may reasonably become qualified by education, training, or experience.
Participation in the Plan depends on the collection, storage, use, and sometimes the destruction of personal information about you, the Member, and your Dependents. It forms the foundation upon which individual entitlements are built, and from which benefit payments are calculated and made. As well, aspects of this personal information are needed to satisfy government demands for facts, to facilitate audits of the Plan, to estimate future operating costs, to inform Members about their accumulated values and to transfer data to any replacement program. As well, the information could be called into a court action. In all cases, however, personal information is stored with the utmost attention to security and deployed sparingly, to fulfill the requirements of the Plan and the law.

Registration to participate in the Plan, involves an authorization to allow the Trustees to gather and apply personal information in specific ways. Members may revoke this authorization subject to certain legal constraints. However, doing so precipitates the destruction of the Member’s personal information on file and may, therefore, render ongoing participation impossible.

Complaints regarding personal information may be directed to the Privacy Officer at the Office of the Administrator, address previously noted, or by contacting the Office of the Privacy Commissioner of Canada or, if applicable, the Provincial Commissioner.
A FINAL WORD ABOUT YOUR BENEFIT CLAIMS

• READ THIS BOOKLET CAREFULLY.

• PROVIDE ALL THE INFORMATION REQUESTED ON THE CLAIM FORM.

• INCLUDE ALL ORIGINAL RECEIPTS, INVOICES, DIAGNOSES, AND OTHER REQUIRED DOCUMENTS, BEFORE THE CLAIM IS MAILED.

• CALL THE ADMINISTRATOR at: (416) 674-3350 or 1-800-461-4361 OR VISIT OUR WEBSITE AT www.ihavebenefits.ca, IF YOU HAVE QUESTIONS.

If you follow these steps you will avoid unnecessary delays in claim reimbursement.