PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

PREMIUM WAIVER — EMPLOYEE STATEMENT FOR TEACHERS

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Phone: 604 419-2000 Toll-free: 1 877 722-2583 Fax: 604 419-8055

PART 1 — EMPLOYEE'S STATEMENT - must be completed by employee

First name	Last name				Date of birth (mm-dd-yyyy)
Street address	Box number (if applicable)	City	Province	Postal code	Phone number
ID number	Policy number	Employer			School District number
Are you now medically unable to work? ☐ Yes ☐ No If yes, provide date last able to work		Date last worked (mm-dd-yyyy)			

Please attach a copy of your Long Term Disability claim approval letter in order to confirm eligibility for Waiver of Premium. This must be submitted within 4 months from the first day of disability, but no later than 6 months from the date your Long Term Disability claim is approved. Failure to do so may result in your Waiver of Premium claim being declined.

I, the undersigned, hereby make claim for the above mentioned benefit. I authorize the release of all reports and medical information which may be needed to establish the validity of this claim to British Columbia Life & Casualty Company (BC Life). I agree that a photocopy of this authorization shall be as valid as the original. I certify that the above answers are true and complete to the best of my knowledge and belief. I understand that my personal information will be dealt with in accordance with the Privacy Policy of BC Life in effect from time to time.

I agree to inform BC Life immediately if my Long Term Disability claim is terminated or closed for any reason.

Signature of employee	Date (mm-dd-yyyy)
X	

0544.002.08—92-60-119—TEACHERS 08/19 CUPE 1816