Waterfront Employers
British Columbia

400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

ILWU – EMPLOYER ASSOCIATION HEALTH AND BENEFIT PLAN
SCHEDULE B

REIMBURSEMENT AGREEMENT - pages 1 to 3

Name of Plan Member/Employee Number: ____

Date of Disability: ____

Cause of Disability: ____

In consideration of the I.L.W.U. - Employer Association Health and Benefit Plan (the Plan) advancing to me Weekly Indemnity and/or Long Term Disability benefits, and/or medical expenses, which I may ultimately be entitled to receive under the Plan, I agree to pursue any reasonable claim that I have against a Third Party or Workers' Compensation and act in good faith with respect to the Plan's rights under this Agreement.

I intend to make a claim or have made a claim against Workers Compensation/a Third Party or the insurer of a Third Party for the losses and injuries I suffered as a result of an accident. I understand that payments made to me by the Plan are made to me in the form of an advance. Any payments received from the Plan will be repaid out of any monies that I receive from Workers' Compensation/a Third Party or their insurer whether by way of settlement, judgement or award.

1. I agree that any claim I advance against Workers' Compensation/a Third Party will specify an amount which reasonably reflects the past and future benefits and/or medical expenses advanced to me and any settlement I enter into will set out the amount which reasonably reflects those benefits and/or medical expense.

2. Unless otherwise agreed to I will pay to the Plan the full amount of the money received by me from the Plan without deduction of any legal fees or expenses incurred by me which fees and expenses are my own responsibilities.

3. I agree to make the repayment described in paragraph 2 as follows:

   (a) If I do not have a lawyer acting for me, I will pay such amount within 15 days of monies being received by me.

   (b) If I am represented by a lawyer, I hereby irrevocably authorize and direct my lawyer to pay such amount directly to the Plan out of monies received, within 30 days of receipt by my solicitor of such monies and prior to any amount being paid to me.

   (c) To pay interest on any unpaid balance at the rate of 1.5 % per month (18% per annum).

4. I agree to forward, or if represented by a lawyer, to direct my lawyer to forward a copy of any judgment, award or settlement confirmation letter within 15 days of the date of any judgment, or award or settlement. I authorize ICBC or the Workers' Compensation Board or any Third Party against whom I am making a claim to release to the Plan all information in their possession relating to my claim for compensation and will sign any release necessary to give effect to this clause. In the event that any of the above parties decline to provide the required information, I agree to provide such information which is in my possession if requested by the Plan administrator.

5. I understand that any failure to abide by the terms of this Reimbursement Agreement will result in the discontinuation of any future advances and demand for repayment of Benefits advanced.

6. Lawyer's name, address and phone no. (if you have one):

   ____

   ____

   If claim resulting from a work related injury or sickness:

   Claim adjuster's name: ____________________ Telephone No. ____________________

   Claim No. ____

   If claim resulting from a motor vehicle accident:

   Claim adjuster's name: ____________________ Telephone No. ____________________

   Claim address: ____

   Claim No. ____

I agree to notify the Plan administrator in writing if there is any change to any of the above information.

____________________________ ____________________________

Witness Signature *Plan Member Signature*

____________________________ ____________________________

Witness Name (please print) *Date*

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ASSIGNMENT

BETWEEN:

THE TRUSTEES OF THE I.L.W.U. - EMPLOYER ASSOCIATION HEALTH AND BENEFIT PLAN

AND:

____
(Plan Member's Name)

I, _______________________, in consideration of the Trustees of the ILWU - Employer Association Health and Benefit Plan "the Plan" advancing to me Weekly Indemnity benefits and/or Long Term Disability benefits and/or medical expenses, HEREBY ASSIGN to the Plan my right to any monies due, accruing due or which may hereafter become due to me from the Insurance Corporation of British Columbia or any insured of that Corporation or the Workers' Compensation Board or any other Third Party arising out of an accident which occurred on the __________ day of ______________, 20____.

The monies assigned under this Agreement are limited to a maximum amount equal to the total amount of money paid to me by the Plan.

I UNDERTAKE to do all such further things as may be required, to give full effect to this Assignment and acknowledge that this Assignment is binding on my heirs, successors and assigns.

____
Date

__________________________ ____________________________________

Witness Signature of Assignor

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INDIVIDUAL'S CONSENT TO THIRD PARTY DISCLOSURE OF PERSONAL INFORMATION

I,____, Employee Number: ________________
(print name)

Date of Birth:____________________, residing at: ____

____, Telephone no:______________________________

do hereby authorize WorkSafeBC (the Workers' Compensation Board of BC), ICBC (Insurance Corporation of B.C.) or any other third party to disclose the following personal information:

- **Status of any claim**
- **Settlement information (date and amount of settlement) and awards**

to:

Waterfront Employers of BC
#400 – 349 Railway St.
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to be used for the purpose of determining Weekly Indemnity reimbursement as per my signed *Schedule B (reimbursement agreement)* and signed *Assignment* of third party compensation.

This consent shall be and remain irrevocable and in effect for a period of one year after any claim is settled.

This consent is required in order to receive advance payment of Benefits*.

________________________________ ____________________________
Signature *Date*