Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta, T6E 5R6
Telephone: (780) 465-2882 Toll Free: 1-800-268-3649
Fax (780) 465-0808 email: claims@ebfa.ca

# SELF-PAYMENT APPLICATION

**TO BE COMPLETED BY THE PLAN MEMBER:**

Name of Plan Member: _____

EBFA Stakeholder Number_____

Email Address:_____

Address: _____
Street Number City Province Postal Code

Phone Number: (_____)_____ Cell Phone Number: (_____)_____

**SELF-PAYMENT POLICY:**

- A Plan Member whose Hour Bank falls below 120 hours or whose Years-Of-Service Bank is fully utilized may continue his Coverage for himself and his Dependents by making Self-Payments.
- The Benefit Packages available to Plan Members who make Self-Payments are limited to those listed in the Plan Rules.
- A Plan Member must make the first Self-Payment and each subsequent Self-Payment to the Fund Office prior to his loss of Coverage.
- A Plan Member's Coverage through Self-Payments will terminate at the end of the month in which the conditions and requirements of the Plan Rules are failed to be met by the Plan Member.

I, THE UNDERSIGNED PLAN MEMBER OF THE ABOVE CAPTIONED FUND, DO HEREBY DECLARE THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE NOTED **SELF-PAYMENT POLICY**.

☐ Self-Payment Package for Plan Members under age 65.
For the month of _____, 20___, in the amount of $351.00.

☐ Self-Payment Package for Retired Plan Members Age 55 to 64.
For the month of _____, 20___, in the amount of $329.00.

☐ Self-Payment Package for Plan Members Age 65 and over.
For the month of _____, 20___, in the amount of $272.00

☐ Self-Payment Package for Retired Plan Members Age 65 and over.
For the month of _____, 20___, in the amount of $256.00.

☐ Self-Payment Package for Active Plan Members under Age 60 on Long Term Disability
For the month of _____, 20___, in the amount of $183.00.

☐ Self-Payment Package for Retired Plan Members under Age 60 on Long Term Disability For the month of _____, 20___, in the amount of $172.00.

Date:_____ Signature: _____

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**REMINDER:**

**This application must be returned with your Pre-Authorized Debit Plan Agreement.**

**Both documents must be received prior to the month of desired coverage.**

Electrical Workers' Benefits Plan
ALBERTA

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# PERSONAL PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT FOR SELF PAYMENT OF HEALTH AND WELFARE PREMIUMS

**PLEASE PRINT**

DATE: _____
(MMM/DD/YYYY)

Plan Member's Name: _____

EBFA Stakeholder Number: _____

Address: _____

_____
Apt # Street Address City Province Postal Code

Phone Number: ( ) _____ Cell Phone Number: ( ) _____

## PERSONAL PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I/we authorize the Electrical Industry Insurance Benefit Trust Fund, and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring self-payments, representing full payment of the self-payment (including increases which occur from time to time) under my Electrical Industry Insurance Benefit Trust Fund account. Regular monthly payments for the full amount of my/our self-payment will be debited to my/our specified account on or before the last banking day of each month, prior to the month of Coverage.

This authority is to remain in effect until the Electrical Industry Insurance Benefit Trust Fund of Alberta has received written notification from me/us of its change or termination. This notification must be received at the address provided above, at least 10 (ten) business days before the next debit is scheduled. I/we may obtain a cancellation form by contacting the Fund Office, or obtain more information on my right to cancel a PAD Agreement at my/our financial institution, or by visiting www.payments.ca

The Electrical Industry Insurance Benefit Trust Fund of Alberta may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement.

I/we understand that if I/we do not have sufficient funds in our account to cover the cost of the Self-Payment, a replacement payment will be accepted on the condition that, an NSF Fee will apply, and I/we will be not receive Benefits Coverage for that month. Any second NSF occurrence will automatically cancel this PAD Agreement and my Benefits will terminate for the month in which the second NSF occurred.

Electrical Workers' Benefits Plan
ALBERTA

# PERSONAL PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT FOR SELF PAYMENT OF HEALTH AND WELFARE PREMIUMS

**Please complete and return all three (3) pages of this agreement to the Fund Office Attention Self Payment Department**

I/we hereby authorize the Electrical Industry Insurance Benefit Trust Fund of Alberta to debit the bank account identified below, for each monthly self-payment on the last day of each month, or the last business day of each month. **I/we acknowledge that I am responsible for the accuracy of the banking information provided on this form. If I/we provide incorrect banking information, I understand that my participation in the program may be impacted.**

Signature of Plan Member: _____ Date: _____

Signature of Account Holder (if not the Plan Member): _____ Date: _____

Signature of Joint Account Holder (if applicable**): _____ Date: _____

Print Name of Joint Account Holder: _____

**Please note we require both account holder signatures on joint accounts including one signatory joint accounts

## BANK ACCOUNT INFORMATION

Please attach a "void" cheque, or have this form completed by a representative at your financial institution.

☐ Chequing Account ☐ Savings Account ☐ Joint Account (Savings or Chequing)

Financial Institution Number: ☐☐☐

Branch Transit Number: ☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Name of Financial Institution: _____

Current Address of Financial Institution: _____

Signature of Financial Representative: _____

Name of Financial Representative: _____

Date Signed: _____