



**IRONWORKERS' HEALTH & WELFARE TRUST
FUND OF WESTERN CANADA**

REQUEST FOR FREEZING OF HOURS

OFFICE USE ONLY	
FREEZING CODE: _____	DATE COMPLETED: _____
MONTH: _____	INITIALS: _____

1. MEMBER INFORMATION			
LOCAL UNION			
LAST NAME	FIRST NAME	GENDER Male Female	DATE OF BIRTH (MM/DD/YY)
ADDRESS			SOCIAL INSURANCE NUMBER
CITY	PROVINCE	POSTAL CODE	PHONE

PLEASE COMPLETE THE APPROPRIATE BOX BELOW

2. REQUEST FOR WORKERS' COMPENSATION BENEFITS FREEZING	Copies of Pay Stubs & Claim # Required
Please be advised that I, _____, the undersigned participant of the Ironworkers' Health & Welfare Trust Fund Of Western Canada, have received payment from Workers' Compensation Benefits for the period indicated:	START DATE (MM/DD/YY)
If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated, up to the maximum period permitted in the Eligibility Rules.	END DATE (MM/DD/YY)

3. REQUEST FOR EI SICKNESS & ACCIDENT FREEZING	Copies of Pay Stubs & Claim # Required
Please be advised that I, _____, the undersigned participant of the Ironworkers' Health & Welfare Trust Fund Of Western Canada, have received payment from Employment Insurance & Accident Benefits for the period indicated:	START DATE (MM/DD/YY)
If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated, up to the maximum period permitted in the Eligibility Rules.	END DATE (MM/DD/YY)

4. REQUEST FOR TRADE SCHOOL FREEZING	Union Approval Date Confirmed: _____ Initials: _____
Please be advised that I, _____, the undersigned participant of the Ironworkers' Health & Welfare Trust Fund Of Western Canada, attended Trade School during the period indicated:	START DATE (MM/DD/YY)
If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated, up to the maximum period permitted in the Eligibility Rules.	END DATE (MM/DD/YY)

I declare that the statements I have made on this form are complete and true. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible, my social insurance number is required for identification and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of my personal information or my spouse and dependents personal information, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

(MM/DD/YY)

SIGNATURE OF MEMBER _____ DATE _____