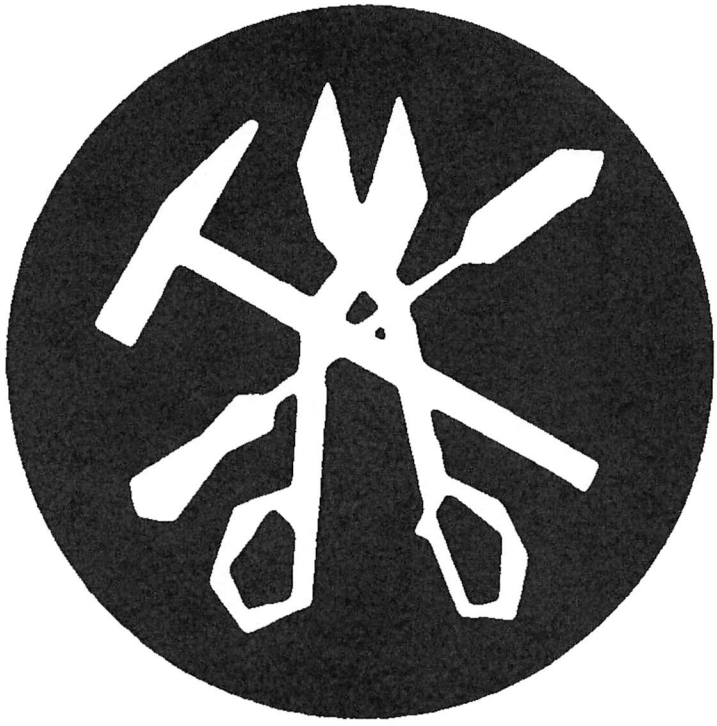

SHEET METAL WORKERS (LOCAL 280)

ASSOCIATE SECTION

SHEET METAL WORKERS (LOCAL 280)
HEALTH BENEFIT AND PENSION PLANS
6192 KINGSWAY, BURNABY, B.C., V5J 1H5
PHONE: (604) 430-3015
MONDAY – FRIDAY: 8:00 a.m. – 4:00 p.m.

TOLL FREE: 1-888-892-1168
FAX: (604) 430-4691
EMAIL: info@smw280benefits.ca
WEB: www.smw280benefits.ca

NAME _____

PBC ID # _____

MSP GROUP # (MEDICAL):	6118319
PBC POLICY # (DENTAL & EXTENDED HEALTH):	1661
SMW L280 HEALTH BENEFITS # (VISION & WAGE LOSS):	32640

PLEASE READ THE FOLLOWING PAGES CAREFULLY – TO MAKE YOURSELF AWARE OF WHAT BENEFITS ARE AVAILABLE TO YOU AND YOUR DEPENDENTS.

THIS BOOKLET INCLUDES EXPLANATIONS OF THE FOLLOWING:

- ☑ GENERAL PLAN INFORMATION
- ☑ HOUR BANK MAINTENANCE
- ☑ DENTAL *
- ☑ EXTENDED HEALTH *
- ☑ GROUP LIFE INSURANCE / ACCIDENTAL DEATH & DISMEMBERMENT *
- ☑ BC MEDICAL
- ☑ SHORT TERM DISABILITY [i.e. WEEKLY or WAGE INDEMNITY]
- ☑ LONG TERM DISABILITY *
- ☑ PENSION
- ☑ POWERS of ATTORNEY / ESTATE PLANNING [inc. WILLS]

* NOTE – These are also available on our website.

IF YOU HAVE ANY QUESTIONS, OR NEED MORE INFORMATION, PLEASE CONTACT US.

This Booklet is intended only to communicate a "user-friendly" summary of Benefits presently provided by your Health Benefit Plan, and does not establish any legal rights or entitlements. Thus, in the event of any difference(s) between this Booklet and the underlying Agreements and/or Contracts – the latter will always prevail.
From this point forward, any reference to 'you' refers to the 'member'.

GENERAL INFORMATION

ELIGIBILITY

Coverage will start on the first of the month after the Health Benefit Plan Administration Office (the "Office") receives 240 hours, with a completed SMW 280 Application Form and a BC Health Insurance Application Form and as long as you are a Member "in good standing" with Local 280.

Hours must be accumulated within a period of 12 months.

An Hour Bank is kept by the Office on behalf of every Member; each hour that we receive a contribution for on your behalf is recorded in an Hour Bank.

Eligibility for coverage: If you accumulate 240 hours in your Hour Bank by the March 31st, the Office would receive this the 2nd to 3rd week in April (the "lag month"), when March reports are received from your Employer(s). The Office will declare you "Eligible for Coverage" May 1st.

All hours worked before the 12-month period prior to coverage will be discarded from the Hour Bank if you have not accumulated 240 hours by the end of the 12-month period.

Lastly, for each month that coverage is granted, your Hour Bank balance will be reduced by 120 hours - which is also known as the "monthly charge".

MAINTAINING COVERAGE

Your coverage will continue as long as you have at least 120 hours in your Hour Bank to pay for the next month's coverage and you remain a Member "in good standing" with Local 280. If your Hour Bank balance is less than 120 hours, you may be eligible to make a self-payment to cover the shortage to bring your balance up to the required 120 hours.
For example, if your Hour Bank at the end of August amounted to 75 hours - you may be eligible to make the required self-payment for the 45-hour shortage by the 19th of September to ensure that you are still eligible for coverage on October 1st. *(The next Section will explain Self-Payments in more detail).*

The office will advise you by mail that a shortage will occur in your Hour Bank balance – WE ARE NOT RESPONSIBLE TO KEEP YOU INFORMED.

it is up to you to be aware of the ongoing balance in your Hour Bank, which can be received by contacting the Office between 8:00 a.m. and 4:00 p.m. Pacific Standard Time, Monday to Friday, or by emailing us at info@smw280benefits.ca

Moreover, please ensure that the Office is informed and kept up-to-date of your current mailing address and phone number(s).

SELF-PAYMENTS

You may cover any shortages in your Hour Bank by making the required self-payments.

However, if said shortage represents a full month, then you are restricted to making full monthly self-payments to a maximum of 6 consecutive months while remaining a Member "in good standing" with Local 280. When regular Employer contributions restart on your behalf, you will then be able to make full self-payments, at a later point if necessary, for another 6-month period and so on.

However, if your membership is suspended from Local 280 and/or if you take a withdrawal or transfer card and/or if a part-paid initiation fee is forfeited, you will be unable to make any self-payments to this Plan.

Shortages of Hours Notices are mailed out each month by the Office. For example, once the August hours have been remitted and reported in the 3rd week of September, and after October's eligibility has been checked, the Office will send a Shortage of Hours Notice to the most current address on file if there are insufficient hours in the Hour Bank to purchase coverage for November.

Should you receive a Shortage of Hours Notice and feel that it is not correct ➔ Contact the Office ASAP. Payments must be received by the due date stated on the Notice.

LIFE INSURANCE ONLY [Unemployed Members only]

You may make self-payments for the full range of Benefits - as explained above - or you may wish to purchase life insurance coverage only (at a fraction of the cost).

If you choose this option, no Billings are sent to remind you to pay and the rules are outlined on the Application Form which is included with your Billing for full coverage.

MAXIMUM HOUR BANK

You can store up to 12 months of coverage in your Hour Bank at the rate of 120 hours for each month of coverage; an annual max of 1,440 hours.

NOTE - Any excess of this maximum amount is credited to the Plan's General Reserve Fund.

TERMINATION

Your coverage will terminate at the end of a calendar month because your Hour Bank does not cover 120 hours for eligibility and you have not paid contributions to make up the difference OR because you are no longer a member of Local 280 OR because you no longer reside in BC.

When your coverage terminates, you have a right to convert your group life insurance into an individual policy (for the same or lesser amount); there are also Conversion privileges with Pacific Blue Cross (PBC) regarding Dental & Extended Health Benefits.
Please refer to the relevant Sections of the PBC Booklets for more details.

RECIPROCITY & RECIPROCAL AGREEMENTS

The Plan has established many formal arrangements with other Sheet Metal and related Construction Trade Locals in both BC and the rest of Canada; and it may be possible for you to transfer credits to/from our Health Benefit Plan.

Please check with the Office to determine if an agreement for a transfer of credits exists; and we will also provide you with information regarding Provincial Medical Coverage.

REINSTATEMENT

If you have "terminated" your coverage – you must re-qualify in the same way as a new entrant.

You must re-accumulate 240 new hours in your Hour Bank and have re-established your "good standing" status with Local 280.

REPORTING "HOURS WORKED"

Each Participating Company contracted to Local 280 is bound by a Collective Agreement to report and remit the required contributions for the hours that you worked for that Company in the previous month by the 15th day of the next month.

For example, your 120 hours of work for 'SMW Sheet Metal Co.' in February 2017 must have been reported and paid for by the 15th of March 2017.

Occasionally errors occur on some monthly reports and/or a report may be submitted after the 15th of the month; so to protect yourself and your Hour Bank from these problems, we urge you to hold on to all your pay-cheque stubs and/or work record sheets and/or whatever else you have received in writing from 'SMW Sheet Metal Co.' that confirms that you did actually work 120 hours in February 2017.

Make sure that the name of the Company appears on these records because, in the event of a problem, the Office may be able to use these documents to supplement your Hour Bank until the official material is presented.

RETIRED BENEFITS

Once you retire, there may be Health Benefit coverage available, please contact the Health Benefit Office for more information.

HOUR BANK MAINTENANCE

If or when you lose work days because you are:

- attending an Apprenticeship Course
- receiving WorkSafe BC payments
- receiving Wage Indemnity payments
- receiving EI Sick Pay benefits

This Plan will credit your hour bank accordingly, subject to the following regulations and conditions:

1. You have filed an application form with the Plan Office. Such forms are available at the Plan Office and must be completed legibly in ink.

2. You must be covered on the Plan at the time the disability commenced, except for Note (a). Credit will not be granted if you have taken a withdrawal card or transfer card or have been suspended from Local 280, or, in the case of Associate Members, have left the employ of a firm contracted to Local 280. Credit will not be granted for claims which occur while in the employ of a non-signatory firm.

3. Application for a credit for Wage Indemnity due to a WorkSafe BC Claim must be made within three months of the accident and is subject to the same restrictions as the claim for payment.

Note (a): Credit will be granted in the case of a WorkSafe BC injury which occurs within one calendar month prior to commencement of Plan coverage, provided that coverage has been earned through hours worked and application for credit has been received by the Plan Office.

Credit will be based on the maximum amount of the charge per month. For example: If you are off work for the entire month, you will be credited with 120 hours, however, if you were off work for only 7 days of the month you will be credited with 56 hours (8 times the number of days). Credit for Apprenticeship Courses will be similarly granted in accordance with the length of the course less the number of days you were away from school.

Credit will be processed in the same manner as regular working hours — there is a lag month. If you are applying for credit in the month of May and

submit the claim form in May, the Plan Office will check and process your claim in June and your credit will appear in your hour bank in June. However, if you do not submit your claim form for time off in May until June, credit will not appear in your hour bank until July.

Credit will be given for WorkSafe BC Claims for a maximum of one year. However, should your claim be reopened or continue longer than one year, you may have your claim reviewed by writing to the Trustees through the Plan Office. As well, credit can be given for up to six months while you are receiving Workers' Compensation Rehabilitation benefits.

Notices of credit granted are sent to your address on file. It is your responsibility to ascertain that your correct address is on file in the Plan Office.

DENTAL

When you and/or your Dependents qualify as "Covered Person(s)", this feature of the Plan will cover the following service costs through Pacific Blue Cross ["PBC"]

- **Plan 'A' – 90% coverage re: Basic Care and Maintenance**
  – including Diagnostic, Endodontic, Periodontics, Preventive, Prosthetic, Restorative and Surgical procedures to restore your teeth to their normal functions. Recall exam, polishing and fluoride eligible 1 per 9 month period (2 per calendar year for children under age 19);

- **Plan 'B' – 70% coverage re: Major Restorative Work**
  – i.e. replacement &/or reconstruction, when Basic Restorative will not work, usually including Crowns, Dentures, Fixed Bridges, Inlays and Veneers;

- **Plan 'C' – 50% coverage re: Orthodontics**
  – subject to a lifetime limit of $3,500 (i.e. 50% of $7,000).

Notwithstanding the above percentages (and the maximum Lifetime Limit in Plan "C") – the actual amounts to be reimbursed will be based on the PBC "Schedule of Fees" [also known as the "PBC Fee Guide"] for the current year.

However, if the Dentist's 'usual and customary fees' are greater than those in the PBC Fee Guide, then these latter amounts will be used to calculate the appropriate reimbursements.

We strongly advise you to always check with the Dentist prior to commencement of any treatment to determine his/her fees for the services that you require – as Dentists are NOT obligated to adhere to the amounts in the current PBC Fee Guide (and, indeed, some don't); and the Plan will NOT cover the difference between what your Dentist may charge and the maximum reimbursement amount payable by PBC.

In other words, any potential difference in fees is your responsibility.

Should your Dentist require that you pay him/her directly, rather than submitting the charges online to PBC, you should determine the following:

A. That the receipt for the work done includes the itemized Fee Guide Codes and the relevant dates of the procedures
   AND/OR

B. That the Dentist either gives you a detailed standard dental claim form with this itemized information contained therein or provides you with details of when such a document was mailed and/or faxed to PBC

We remind you that any changes concerning your Dependents must be sent to our Office and not to PBC.

Lastly, further details of the benefits, limitations, coverage's and conditions are contained in the enclosed PBC booklets and may also be downloaded from our website.

Moreover, you should enroll online with PBC's CARESnet @ www.pac.bluecross.ca/caresnet

– To view your up-to-date Dental and Extended Health Claims History, limits and current bank account information.

EXTENDED HEALTH CARE

When you and/or your Dependents qualify as "Covered Person(s)", this feature of the Plan will cover the following service costs through Pacific Blue Cross ["PBC"]

- $100 Annual Deductible (per Family; or per Member if no other Covered Persons)
- 80% to $1,000 (as refunded to each Covered Person) ➔ then 100%
- $3,000,000 Lifetime Limit (per Covered Person)

The main benefits under the Plan for each Covered Person are as follows

- ☑ **Prescription Drugs** [No annual limit]*
- ☑ **Paramedical** [$1,500 annual limit] i.e. Acupuncturist, Chiropractor, Massage Therapist, Naturopath, Physiotherapist, etc.
- ☑ **Psychologist** [$1,000 annual limit]

Notes

[a] Effective April 2009, you may pay for most of the cost of your Prescription Drugs using a 'Pay Direct' Card – which allows the Pharmacy to collect the insured amount directly from PBC (requiring that you pay only the amount(s) NOT covered by PBC).

[b] Also, effective April 2009, Dispensing Fees for Prescription Drugs are no longer covered.

[c] PBC's Prescription Drug program is, by law, integrated with Pharmacare.

*Subject to Pharmacare low cost alternative; however, this will not apply if it has been shown that such medication does not meet the patient's needs.

We remind you that any changes concerning you and/or your Dependents must be sent to our Office; **NOT to PBC or MSP**.

Lastly, further details of the Benefits, limitations, coverage and conditions are contained in the PBC Booklets available from the Office which may also be downloaded from our website.

Moreover, you should enroll online with PBC's CARESnet @ www.pac.bluecross.ca/caresnet – to view your up-to-date Dental and Extended Health Claims History, limits and current bank account information.

There are 3 additional benefits covered by your Plan; Administered / adjudicated by the Health Benefit Plan Administration Office as follows

1. EMERGENCY MEDICAL TRAVEL

NOTE – This is NOT the same as "Travel Insurance" ➔ The details can be found in the Pacific Blue Cross Booklet and/or via www.pac.bluecross.ca.

The Plan will consider payment of Emergency Travel Assistance benefits on behalf of eligible members or their covered dependents.

The office must receive the above within 60 days of the occurrence of the claim; Emergency Travel Assistance operating rules may be amended from time to time at the discretion of the Plan Trustees.

Where in the written opinion of the attending physician treating you and/or your dependents as recognized by the Plan, adequate treatment is not available locally, transportation beyond a 160–km distance, by regularly scheduled airline to and from the nearest locale equipped to provide the required and recommended diagnosis and/or treatment by a physician and surgeon within 12 months of referral.

A. Original receipts for expenses incurred must be itemized and submitted. Claims without original receipts or referrals will be returned and will not be reimbursed until all required information is provided.

B. When original receipts for food purchases are submitted, the maximum reimbursement per day will be $50.00 for an individual or $100.00 for a family, for a maximum of seven days.

C. Transfer transportation between airport and hospital or hotel, when supported by original receipts, will be reimbursed at the maximum rate of $40.00 for the day of arrival and $40.00 for the day of departure.

D. The limit for travel costs is set at 75% of an economy class airfare where applicable or 75% of expenses for other modes of travel;

E. If travelling by car, submit all original gas receipts, including the fill up on the date of return. Reimbursement will be the lesser of the current CRA limit of $0.52 per km (with MapQuest details) AND the costs of gas tank fill ups per submitted receipts. These original gas receipts will be reimbursed at 75%;

F. When original receipts for accommodation are submitted, the maximum reimbursement per day will be $80.00 for a maximum of seven days.

G. Plan will reimburse on a maximum of six trips per family per year.

H. Where necessary, and at the written request of the attending physician, provision for transportation of an attendant in connection with the aforementioned transportation of you and/or your recognized dependent.

Prior to reimbursement for Emergency travel, the following must be satisfied

- Completion of Application Form provided by the Office.
- Documentation of referral by attending physician or surgeon recommending said referral.
- Documentation of treatment by the physician or surgeon to whom the patient was referred.
- Original Dated itemized receipts.

2. HEARING AIDS

Forms are available at the Office and the reimbursement rate is 80% with a maximum limit of $1,000 – *per ear* – every four-year purchase period.

Payment will NOT be made for maintenance, batteries or recharging devices, or other such accessories.

Note – "Hearing protectors" are not included in this coverage; as these are commonly supplied through other sources.

3. VISION CARE

Claim forms are available from the Office and/or may be downloaded from www.smw280benefits.ca under the Health Benefit section.

You and/or your Dependents are covered for

- ☑ Eye exams
- ☑ Prescription Eyeglasses
- ☑ Contact Lenses
- ☑ Corrective Laser Eye Surgery

Reimbursement for Eye Exams, Prescription Eyeglasses, Contact Lenses and Corrective Laser Eye Surgery will be processed by the Sheet Metal Workers (Local 280) Benefits Administration Office. The eligible reimbursement for each member or dependent covered at the time of purchase is 100% of eligible expenses to a maximum of $500.00.

1. Reimbursement will only be made upon completion of the Vision Care claim form and submission of all receipt(s).

2. Reimbursement for Corrective Laser Eye Surgery will be accepted with eligible receipts. This Plan is not endorsing the surgical procedure and does not assume responsibility for any problems arising there from.

3. The start date of a 24 month period for a covered member or dependent shall be determined by his or her first purchase date of eligible Vision Care. This anniversary date will remain constant for the life of the member or dependent coverage. **You must be covered at both the purchase AND submission dates (eligible purchases submitted within 30 days of coverage cancellation will be covered).**

4. Eligible Vision Care receipts can be submitted up to a maximum 24 months from the purchase date.

5. If the reimbursement limit has been reached in a 24 month period, new eligible purchases made during that period can be carried forward to the next period. WE WILL ONLY REIMBURSE RECEIPTS ONCE; ANY UNINSURED PORTION MAY NOT BE RE-SUBMITTED AT YOUR NEXT ANNIVERSARY DATE.

6. You may submit for **out of province or online purchases**, but you must provide **ALL of the following:**
    a. a paid receipt;
    b. a **packing slip** for proof of delivery for online orders;
    c. a copy of your credit card statement* showing the Canadian dollar conversion can be submitted with your claim, otherwise the Bank of Canada exchange rate in effect on the purchase date will be used.

***Please remember to blank out ALL other credit card information, leaving only the vision care purchase and exchange rate visible.**

**In situations of separation or divorce, the following order applies:

1. the plan of the parent with custody of the child;
2. the plan of the Spouse of the parent with custody of the child;
3. the plan of the parent not having custody of the child; and
4. the plan of the Spouse of the parent in 3) above.

GROUP LIFE INSURANCE

Your Group Life Insurance coverage is $75,000

On attaining age 65, this coverage will reduce to $30,000 and thereafter annually by $5,000 until the fixed amount of $10,000 (effective age 69 and over) is reached; all subject, of course, to our receiving contributions on time and the continuation of the Health Benefit Plan and the underlying Group Life Insurance policy without amendment.

Note – your Group Life Insurance is monthly "Term Insurance" i.e. there is no buildup of any Cash Value and no identity cards or individual policy documents are issued as 'proof' of coverage.

DESIGNATING YOUR BENEFICIARY

You designate your beneficiary when you complete your Application Form. If you have not named a beneficiary or your form is incorrect, your Group Life Insurance will, by law, be payable to your Estate. You may designate a different beneficiary by requesting a Change of Beneficiary form, completing it and sending to our Office.

Note – When naming a Beneficiary we require complete given name and surname as well as the relationship to you. *For example, "Mary Jane Doe (wife)" – **not** Mrs. M. J. Doe (wife)" – and your signature must be witnessed by someone who is neither a Beneficiary nor a member of your family.*

CONVERSION OF YOUR GROUP INSURANCE POLICY

Upon termination from the Plan, you are generally permitted **to apply directly to the insurance provider** to convert the Group Life Insurance to an individual insurance policy – without evidence of insurability.

The individual policy is usually restricted to the in-force Group Life Insurance coverage (not including the Premium Waiver provision) and the conversion must be implemented within 31 days after termination of your Group Life Insurance; during which time you will remain insured under this Plan (regardless of whether or not you actually apply to **the insurance provider** to convert to an individual policy).

Generally, you are not permitted to convert to individual policies if your Group Life Insurance coverage has been terminated due to termination of the actual Group Life Policy as a whole.

TOTAL DISABILITY

If you become totally disabled before age 65 **AND** qualify for Long Term Disability **["LTD"]** Benefits, your Group Life Insurance coverage may be kept in force without contributions from you and/or premiums remitted to **the insurance provider** as long as you continue to receive **LTD** benefits.

ACCIDENTAL DEATH & DISMEMBERMENT

In the case of an accident, the amount payable to you or to your Beneficiary is determined by the **TABLE OF LOSSES** listed below.

All calculations of amounts payable are based on percentages of the Group Life Insurance benefit (the "Principal Sum"); which is $75,000 for Members under 65, for example.

This coverage ceases at age 70 – or retirement if earlier.

TABLE OF LOSSES *	Payable to	% times Principal Sum
Life	Beneficiary	100.00
Both Hands or Feet	You	100.00
Entire Sight of Both Eyes	You	100.00
One Hand and One Foot	You	100.00
One Hand and Entire Sight of One Eye	You	100.00
One Foot and Entire Sight of One Eye	You	100.00
Speech and Hearing	You	100.00
One Arm or One Leg	You	75.00
One Hand or One Foot	You	75.00
Entire Sight of One Eye	You	75.00
Speech or Hearing	You	75.00
Thumb and Index Finger of the Same Hand	You	33.30
Four Fingers of the Same Hand	You	33.30
Hearing in One Ear	You	25.00
All Toes of the Same Foot	You	25.00
Quadriplegia, Paraplegia, Hemiplegia	You	200.00

* Notwithstanding the appropriate amount payable on your death, the Policy will compensate you for "Loss of Use" benefits payable if such loss is total, permanent and has been continuous for 365 days from the date of the accident and/or the onset of the life-changing illness.

Lastly, the above is only a listing of the key elements of your AD&D Insurance Benefit – and for all Benefits summarized herein we urge you to refer to the **Insurance Provider** Booklet available from the Office and/or online for further details about this Coverage.

Payment

Because you must enroll your Spouse for the spousal dependent life insurance benefit, when your eligible Spouse dies, we will pay the benefit amount to you.

Waiver of Premium

If your group term life insurance premium is waived because you are totally disabled, your premium for the spousal dependent life insurance benefit will also be waived.

Exclusions

A Spouse not residing in Canada or the USA or a Spouse who is a member of the armed forces in any county is not eligible for the spousal dependent life insurance benefit.

Claims

We must receive notice of the death within **30 days** and a completed claim form along with any proof required, within **90 days**. However, no payment will be made on any claim submitted later than **1 year** from the date of death.

WAGE INDEMNITY (WI)

THIS COVERAGE DOES NOT APPLY IF YOU ARE IN RECEIPT OF SMW 280 PENSION PLAN PAYMENTS

- You must be covered on the Health Benefit Plan at the onset of the disability.
- **WI Benefits** will be paid from the 1st day of disability due to a non-occupational accident, or the 4th day of an illness; providing that you have seen a doctor on the day of the accident or within the first 4 days of an illness.

  Otherwise, payments will begin from the date first seen by a Physician and/or Surgeon in relation to the specific disability.
- Payments can be made for up to 17 weeks of disability while under the continuing care of a Physician and/or Surgeon; or for 6 weeks if solely under the care of a Chiropractor.
- Medical updates will be required at least monthly – and/or more frequently in some circumstances – and the cost for these is NOT covered by the Health Benefit Plan.

WI Benefit payments related to substance abuse may be made only when you are actively participating in an appropriate Rehabilitation Program or process.

"NO TREATMENT ➔ NO BENEFITS"

It is the policy of this Plan to maintain the same level of WI Benefits as are paid under the Employment Insurance Sickness ["EI"] Benefits program AND to incorporate the same age limitations and regulations used in that program to determine our WI Benefits payable.

Thus, any WI payments may be reduced, **after age 60**, by the amount of any Canada Pension Plan ["CPP"] Retirement payments received.

Making a Claim (This Plan is your first payer BEFORE any EI Benefit Claim is filed)

- ☑ Application for Benefits must be made within 30 days of the date when disability commenced. Failure to file a Claim within such time shall not invalidate nor reduce any claim if it is shown satisfactorily that you gave notice as soon as was reasonably possible

- ☑ To claim benefits you must be totally disabled and prevented from working for wage or profit because of your injury or illness
- ☑ The disability must be supported by documented evidence that you are under the expert care of a Physician and/or Surgeon
- ☑ Contact the Office and request WI Application Forms

  Complete the "Claimant's Statement", sign and date the Form; and ensure that the Assignment portion has been witnessed as required. Complete the non cash form to receive health benefit hours while on Wage Indemnity. Ensure that your Physician and/or Surgeon completes the "Physician's Statement" in as much detail as possible.
  Any charges made by your doctor for completing the Form are <u>not</u> covered by any part of the Plan and are therefore your own responsibility

  Ensure that any/all "Expected Return-To-Work" dates have not been left blank or show 'unknown'. If no date or 'unknown' is indicated, you will be required to submit medical updates bi-weekly.
- ☑ Return the <u>completed</u> forms to the Office.

  Please note that incomplete forms could result a delay in the assessment and/or payment of any WI Benefits. Benefit cheques can be either mailed to you or collected in person from the Office.

PAYMENTS

- WI payments will be made on a bi-weekly basis for as long as you continue to qualify.
- Because WI payments are considered to be "taxable income" (but not taxed by the Office at source) you will thus receive a T4A Form in February of each year denoting the amount of income to include in your Tax Return for the previous year.

INVOLVEMENT OF A 3RD PARTY

At the discretion of the Trustees and upon completion of the required Assignment Form(s), WI Benefits may be **"advanced"** to you if your disability occurred due to an accident in which a 3rd Party is liable (e.g. as a consequence of being injured in an automobile accident).

HOWEVER – you must undertake the collection of these amounts [which

may also include the cost of maintaining your Hour Bank for up to 17 weeks] and refund them in full to the Plan.

The Assignment Form included in your Claim Form package must be fully completed before benefits can be paid.

Third parties include ICBC, WorkSafe BC or any other entity that has most likely caused the disability resulting in your having to retain legal counsel to seek lost and/or future income compensation.

If your Claim arises due to a vehicle accident, and you later receive an ICBC settlement, we will advise ICBC and your legal counsel of your total WI Benefit obligation at the end of your Claim; and expect that this amount [i.e. Benefits and Hour Bank costs, if any] will be fully repaid within 30 days.

PLEASE NOTE

[a] No WI Benefits will be advanced to you for a 3rd party claim when you still owe the Plan a reimbursement from a previous 3rd party Claim Settlement.

[b] At the sole discretion of the Trustees, your Dental and/or Extended Health Benefit Coverage *may* be suspended (and potential Claim Refunds held back) until any/all outstanding 3rd Party repayment amounts have been settled.

EXCLUSIONS

No WI benefits will be paid for periods of disability due to the following

1. Is Disabled due to occupational injuries or illnesses;

2. Is Disabled due to self-inflicted injuries or illnesses (with the exception of alcohol or drug addiction);

3. Is Disabled due to his willful participation in war, riot, insurrection, disorderly conduct or unlawful assembly;

4. Is Disabled due to his commission of any unlawful act, including an offence under the Criminal Code of Canada;

5. Is absent from work due to a pregnancy-related illness;
   a) If the Member is absent from work because she is taking a period of formal maternity leave pursuant to provincial or

federal law, or pursuant to mutual agreement between the Member and her Employer; and/or

b) If the Member is in receipt of Employment Insurance Maternity Benefits;

6. Is absent from work due to being institutionalized in a penitentiary, jail or mental facility pursuant to a court order;

7. Is Disabled leading to a claim for benefits commenced prior to the date the Member was covered under the Plan or commenced during a period for which the Member is not eligible for benefits for any reason unless the Trustees otherwise agree in writing;

8. Is in receipt of any salary or wages from any occupation, including without limitation, the Member's Normal Occupation;

9. Is Disabled due to an Illness or Injury he sustained while in the Armed Forces of any country;

10. Is Disabled and in receipt of WCB payments in respect of the Disability that led to a claim for benefits being made under the Plan;

11. Is Disabled and in receipt of pension payments from the Sheet Metal Workers (Local 280) Pension Plan.

TERMINATION (or CONTINUATION) OF WI BENEFIT PAYMENTS

If you are disabled and return to work on a **"full-time full-pay"** basis for less than 2 full consecutive weeks and again become disabled as a result of the same or related cause, it shall be considered a **continuation** of the 1st period of disability.

If, however, you return to work for 2 full consecutive weeks or more and again become disabled as a result of the same or a related cause, it shall be considered a **new** period of disability with new waiting periods, if any, and subject to a new maximum period of benefits.

POTENTIAL EXTENSIONS OF WI BENEFITS

Where there is no 3rd Party liability involved and the illness or injury continues beyond the 17-week maximum payout period, you must then apply for EI Sickness Benefits.

- If you are generally approved for payments under the EI program – and if it appears as if the maximum 15-week payout period will be

reached – the next course of action is to obtain the assistance of the Plan Office to apply for Long Term Disability ["LTD"] Benefits at about week # 9 of the EI payout period [see next Section].

- If, however, **through no fault of your own**, EI Sickness Benefits will not be paid, you may appeal to the Trustees (using a special Form that we will provide) to receive an extension of WI Benefits up to a maximum of 15 weeks on a discretionary basis.

  Again, our Office will assist you if necessary with an Application for LTD Benefits.

INTERRUPTED WORKSAFE BC CLAIMS

Notwithstanding Exclusion #5, this Plan will consider payment of WI Benefits while you are disabled during periods of delay, interruption or suspension of WorkSafe BC payments, after at least 45 days have elapsed since

- you filed a WorkSafe BC Claim which has been neither accepted nor rejected, or
- payments of WorkSafe BC benefits were suspended during an interrupted Claim, or
- you have filed a formal appeal to continue receiving WorkSafe BC benefits.

WI Benefits can only be paid while WorkSafe BC payments are not being paid and the maximum payment period for such benefits is 17 weeks.

Any WI Benefit payments made to you in the above stated circumstances **MUST BE reimbursed to the Plan (within 10 days of receipt of WorkSafe BC payments) once WorkSafe BC is reinstated or begins payment of your Claim for the time in question.**

LONG TERM DISABILITY - LTD

DEFINITIONS

- **Elimination ("Waiting") Period** – Is calculated as **32 weeks** with specific reference to
  - **17 weeks of approved WI Benefits – payable through the Administration Office**
    plus
  - **15 weeks of EI Sickness Benefits – payable through the Federal Government.**

***However**, if you do not qualify for **EI** Benefits – for a legitimate reason (e.g. insufficient **EI** hours) – you may request the intervention of the Trustees to consider a one-time extension of your **WI** Benefits; but it should be noted that any such reviews and subsequent decisions are completely at the discretion of the Trustees.*

- **Initial Disability Period** – 12 months.
- **Disability** – During the Elimination AND Initial Disability Periods, you are adjudged to be in a state of complete and continuous incapacity, which wholly prevents you from performing the substantial duties of your <u>own occupation</u>.

  Following the 12-month Initial Disability Period, it is a state of incapacity preventing you from performing the duties of <u>any occupation</u>.

BENEFIT DETAILS

- **Basic Monthly Benefit Amount** – $1,750
- **Taxable Status** – The Benefit is taxable in your hands. Thus – you will receive a T4A Form in February of each year denoting the amount of income to include in your Tax Return for the previous Year.
- **Offsets i.e. Reductions applied to the Basic Monthly LTD Benefit**

  The afore-mentioned monthly LTD Benefit of $1,750 will be reduced by Gross Benefit amounts paid (or deemed payable by the insurance provider) by the following
  - **WorkSafe BC**
- **All-Source Maximum** – 85% of your Gross Monthly Income as determined at the onset of the disability.

Indirect Offsets included in this calculation are such items as Private Disability Insurance Income, CPP Retirement Income, Other (non-SMW 280) Retirement Income.

- **Maximum Benefit (Payout) Period** – The earlier of age 65 or your retirement.
- **Medical Updates** – will be required as often, and in as detailed a manner, as deemed necessary by the Disability Claims Management Department of **the insurance provider**.
- **Health Benefit Coverage** – While you receive LTD Benefits, your continued eligibility for BC Medical, Dental, Extended Health and Vision Care Benefits may be maintained by transferring to the Retired Members' Group Plan #001664; under which arrangement you will be expected to cover the un-subsidized portion of the full cost of the Monthly Premiums.

Note *– No Life Insurance or Accidental Death & Dismemberment Premiums are required due to the "Waiver of Premium" provision in the LTD Policy*

EXCLUSIONS

No benefit is payable:

1) During any period when the Member is:
    a. Imprisoned in a jail or penitentiary
    b. Entitled to vacation or vacation pay
    c. Receiving sick pay
    d. On leave of absence
    e. Involved in a strike or lockout, if the disability commences after notice of strike or lockout has been given
    f. In receipt of a disability or retirement pension from the Sheet Metal Workers (Local 280) Registered Pension Plan
2) For any disability resulting directly or indirectly from, or in any way associated with, any of the following:
    a. War, whether declared or undeclared, or any act of war or participation in a riot, insurrection or civil commotion
    b. Participation in or commission of or attempt to commit a criminal offense
    c. Intentionally self-inflicted injury or sickness while sane or insane
    d. Active duty in the military forces of any nation or international organization, or in any civilian noncombatant unit which serves

with such forces in combat

e. Substance abuse, including but not limited to alcoholism or drug addiction, unless the Member is confined in a public general hospital or is satisfactorily participating in a substance withdrawal program that we have approved
f. Medical or surgical care wich is cosmetic, unless such care is rendered as a result of an Injury or Sickness and is considered medically necessary

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SUBROGATION and/or THIRD-PARTY INVOLVEMENT

The Insurance provider is entitled to be "subrogated to" (i.e. to be considered as being owed a portion of) your rights and/or entitlements to any amount which may be recovered from a 3rd Party for loss of income for injury or other damages caused by said 3rd Party; but only to the extent of amounts paid or payable to you under this LTD Program.

Generally, the Subrogation process is very similar to that as outlined in the previous Section on Wage Indemnity; however the key difference is that, under the LTD Program, You will be dealing with the insurance provider – and their lawyers, most likely – in the resolution of any matters regarding the settlement of outstanding issues and/or monies owing.

REHABILITATION ASSISTANCE

The insurance provider ***may*** require that you participate in a "reasonable and appropriate" Rehabilitation and/or Progressive Return-To-Work Program to aid your transition back to the workforce; and this generally occurs with the cooperation of your Employer.

PARTIAL DISABILITY

Occasionally you may continue to satisfy the definition of "Disabled" but may also be in a position to work on a part-time basis.

In these cases, the sum of the LTD Benefit and the part-time remuneration may not exceed the gross monthly income in payment at the onset of the disability. If this does happen, the LTD Benefit will be reduced accordingly.

PENSION SUMMARY

GENERAL

This Summary has been prepared to provide you with a brief overview of the key provisions of your Sheet Metal Workers' (Local 280) Pension Plan – the **SMW 280 Plan** – and if you require further information, please contact the Pension Plan Office [the "**Office**"].

The Plan was created by an Agreement and Declaration of Trust (effective April 1st, 1964), it is governed by 6 Trustees (3 from the Union and 3 from Management) they have obligatory reporting requirements to the Superintendent of Pensions in BC and to Canada Revenue Agency and must deliver periodic information to all members and beneficiaries of the Plan.

This is only a summary of the Plan and should not be relied on for legal purposes. The actual Pension Plan Text shall prevail in all instances, including any/all situations where there may be inconsistencies between this document and the provisions of the Pension Plan Text.

NOTE – The Plan documents are available for viewing at the Plan Office during normal business hours.

CREDITED SERVICE

The Plan awards Service Credits that are generally based on the number of Hours Worked by you under the Collective Agreement for which the Required Employer Contributions are made by the Participating Employer(s).

There are 2 types of Service, as follows

- **Frozen Service** based on credits earned in previous years prior to a period of not receiving pension contributions / non membership of 2 or more years.
- **Current Service** is credited for work after the date that your Participating Employer began to contribute to the Plan on your behalf.

Once you become a Plan Member, the Office maintains a comprehensive record of your Hours Worked that is then used to calculate your Service Credits for the appropriate year(s).

Under the current Service Credit formula – if you work 1,200 or more hours in a calendar year you will be credited with a full year of Earned Pension Credit. If you work less than 1,200 hours in a year, you will receive 1/12th of a year's Earned Pension Credit for each block of 100 hours.
For example – if you work 548 Hours, you will earn 5/12th of a year of Earned Pension Credit.

RETIREMENT – DEFINITIONS AND BENEFITS PAYABLE

Normal Retirement

Notwithstanding age 65 being so defined, you may retire at any age between 55 and 71, in accordance with your wishes, subject to Applicable Legislation and per the Plan's provisions.

Pension at Normal Retirement Age

- For each year of Past Service,(prior to January 1, 2016) you will receive the monthly pension that is shown on your current 'Pension Statement'
- For each year of Current Service, you will receive the monthly pension that is shown on your current 'Pension Statement'.

NOTE – Pension Benefits based on "Frozen Service" remain fixed at the Pension Benefit Rate(s) in effect on the date(s) on which your Credited Service was deemed Frozen.

Given that the Pension Benefit Rate has changed 22 times since 1964 (when the rate was $5.00 p.m. per year of Service) – there are any number of combinations of Frozen Service calculations that might comprise your overall Monthly Pension payable at age 65.

Early Retirement

Once you are vested and have attained age 55, you may apply for an early retirement pension.

Under certain circumstances, you may be able to retire at 60, with no reduction in your pension, or at age 55 to 59 with a reduced pension. Any other retirement (i.e.frozen/terminated) prior to age 65 a full actuarial reduction will apply.

Choice of Options

Upon your retirement, you (and your Spouse, if applicable) will be provided with a full list of Monthly Pension Options prior to the recommended appointment with the Plan Administrator.

For example, you may choose to increase or decrease the amount payable to you and/or your Spouse or lengthen, shorten or eliminate the guaranteed period.
Moreover, if you retire before age 65 from Covered Employment, you are permitted to choose a Monthly Pension payment that is integrated with Old Age Security pension.

NOTE - If you have a Spouse at the time of your Retirement, you both must initially consider the election of a Joint Life and Last Survivor Monthly Pension benefit that will continue to your Spouse, upon your death, in the amount of 60% or more of the amount that you were receiving prior to your death. You may decline this Option but only if your Spouse signs a specific Waiver Form.

The following Table illustrates the Options payable to a Member retiring at age 60, after 40 years of Service, with a Spouse who is 2 years younger than he is. For convenience, we will use the Monthly Pension of $2,340.

	Monthly Pension Options at Member's Age 60 Spouse assumed to be age 58			
Opt.	**Description**	**Pre-65 Amount to Member**	**Post-65 Amount to Member**	**Amount to Spouse or Beneficiary**
1	Single Life Annuity Guaranteed for 180 payments (15 years)	$2,250	$2,250	$2,250
2	Single Life Annuity Guaranteed for 120 payments (10 years)	$2,300	$2,300	$2,300
3	Single Life Annuity Guaranteed for 60 payments (5 years)	**$2,340**	**$2,340**	**$2,340**
4	Single Life Annuity	$2,360	$2,360	N/A
5	Single Life – No Guarantee; OAS integration	$2,560	$2,260	N/A
6	Joint Life 100% Guaranteed for 120 payments	$2,020	$2,020	$2,020
7	Joint life 100% Guaranteed for 120 payments OAS integration	$2,220	$1,920	$2,020
8	Joint Life 75% Guaranteed for 120 payments	$2,080	$2,080	$1,560
9	Joint Life 75% Guaranteed for 120 payments OAS integration	$2,280	$1,980	$1,560
10	Joint Life 60% Guaranteed for 120 payments	$2,120	$2,120	$1,270
11	Joint life 60% Guaranteed for 120 payments OAS integration	$2,320	$2,020	$1,270

THE APPLICATION PROCESS

Before you decide to retire, the following Application Process should be reviewed – and please note that we require **at least 2 months written notice** of your intention to retire prior to your selected retirement date.

If we do not have this notice – we **may not have enough time** for your application to follow the normal process which could result in a delayed retirement date.

Please discuss the process with the Health Benefit and Pension Office as required.

NOTE – In the event of a Marriage Breakdown, we will insist on establishing whether or not there exists any obligation on our part to recognize the potential division of your Pension Plan Assets in favor of your ex-Spouse.

We need to review the relevant paragraphs of the Court Order / Separation Agreement to be assured that we have done our due diligence; and, in the event of the unavailability of such documents, we will require you / your ex-Spouse to sign certain forms that would permit us to proceed with your retirement.

DISABILITY BENEFITS

- **If the disability occurred prior to April 1st 2011**

  Monthly Disability Pension benefits were unreduced pensions payable only after the Trustees had determined that the Member satisfied the eligibility criteria.

- **If the disability occurs on or after April 1st 2011**

  If you satisfy the Disability criteria of the Health Benefit Plan (and are thus receiving a Long Term Disability benefit from that source), you will be entitled to receive equivalent years /months of Credited Service to augment your Earned Pension.

NOTE - Returning to Work after Retirement

You can choose to work in any employment outside the Trade and/or Industry, without restriction, as far as your pension is concerned; however, certain restrictions apply if you wish to return to this particular Trade / Industry.

- If you return to "**Non-Covered Similar Employment**" – your pension will be frozen at its current rate, any OAS Bridging options can be suspended and any Health Benefit Plan Coverage for you and/or your Dependents **will be automatically terminated.**

- **If you return to "Covered Employment"**

  - Between ages 55 to 60 – your pension will be temporarily suspended for a minimum of 6 months.
    Subsequent Required Employer Contributions will be credited to your Account and added to your pension; which will resume in the original chosen format (e.g. Joint Life 60%, say) upon your eventual application for re-retirement.

  - Between ages 60 and 65 – in addition to the above option, you have another choice.
    You may return to "Covered Employment" no earlier than 2 months after your 60th birthday **without** suspension of your pension or Health Benefit coverage. This is conditional on your having retired and received 2 pension payments after age 60 before the return to work.

    Going forward, your Employer must remit Required Contributions on your behalf to the Pension Plan (and, indeed, to ALL funds per the Collective Agreement); **HOWEVER** your Monthly Pension benefit will not increase due to these Contributions, although your Health Benefit Plan Hour Bank will reflect them.

DEATH BENEFITS [PRE-RETIREMENT]

If you are vested and you die prior to retirement, your Beneficiary will receive **the greater of:**

[A] The Commuted value of 60 monthly payments of either

- **[i]** 100% of the pension that you earned to the date of your death if you were over 55*
  or
- **[ii]** 50% of the pension that you earned to the date of your death if you were under 55;

OR

[B] 100% of the Commuted Value of the pension that you earned to the date of your death.

* Note – This amount is increased, if necessary, in situations for anyone (over 55 and vested) who dies **after** filing an "Application to Retire" Form but **before** actually receiving the 1st payment; so that Option **[A][i]** equals the Commuted Value of the benefit that would have been payable per the optimal form selected had you retired the day before you died.

TERMINATION BENEFITS

If your pension is vested and your total "Hours Worked" in 2 consecutive calendar years is less than 350, you will be deemed "Terminated" on December 31st of the 2nd such year.

Your Monthly Pension is then "frozen" at the Pension Benefit Rate in effect at that time; and will not generally increase over time [although see below for some exceptions to this rule].
Assuming that you are not over age 55 at the time, the Office will automatically send you paperwork to allow you to choose between transferring the Commuted Value of your Earned Pension out of the Plan or remaining in the Plan as a Deferred Pensioner; and thus entitled to receive a monthly pension benefit at any age between 55 and 71.

This opportunity to transfer the Commuted Value **will not be given to you again** – and if we do NOT receive your decision within 90 days of sending you the Option Statement, the Trustees have instructed us to consider you (**by default**) as having elected to remain in the Plan.

However, if you elect not to remain in the Plan, you will be entitled to transfer the Commuted Value of your pension to a LIRA (locked in retirement account. LIRA e.g.a Locked-In RRSP) or a regular RRSP to a Life Income Fund (LIF), to another registered pension plan (if their provisions permit such a transfer) or an Annuity contract from an Insurance Company.

There are special provisions in our Plan Text to deal with Commuted Values that are less than certain prescribed levels; and these would be clarified for you at the time.

The main advantages of choosing to remain in the Plan as a Deferred Pensioner are that (**should you ever return to Covered Employment**) any newly-earned credits shall automatically be vested **AND**, under certain circumstances, your prior "Frozen" credits will be restored to the current Pension Benefit Rate in effect.

NOTE – Exemption from Freezing
If you must leave the Plan because of disability, but you are unable to qualify for either a LTD Pension (pre-April 1st 2011 provisions) OR continued accrual of LTD Credits (post-March 31st 2011 provisions), you may be able to apply for an "Exemption From Freezing" – and please contact the Office to discuss the implications and benefits of this unique provision.

DISCONTINUANCE OF THE PLAN

The Trustees may suspend or discontinue the Plan upon written instruction from the Union or after a reasonable determination that contributions to the Plan have been discontinued and are not likely to be resumed within the foreseeable future. Regulations for such action are outlined in the Plan Text.

On Plan termination, benefits may be reduced if the Pension Fund is not sufficient to meet the liabilities of the Plan. The termination of the Plan and the associated wind-up of the Pension Fund shall be done in an equitable manner with the assistance and advice of the Plan's Actuary and in accordance with Applicable Legislation.

POWER OF ATTORNEY/ESTATE PLANNING [INC.WILLS]

NOTE – THIS IS NOT A LEGAL DOCUMENT NOR SHOULD IT BE CONSIDERED AS IMPARTING ANY LEGAL ADVICE; RATHER IT IS A BRIEF SUMMARY OF SOME OF THE MAIN POINTS REGARDING THE ABOVE TOPIC. FOR THIS REASON, WE STRONGLY ADVISE YOU TO CONSULT A LAWYER* TO PROPERLY DISCUSS AND DOCUMENT YOUR NEEDS IN THIS AREA.

POWERS OF ATTORNEY ["POA"]

- Can be used to ensure that your wishes regarding your financial AND/OR health affairs will be handled properly should you ever be declared unable to look after yourself;
- There are usually 2 kinds
  - Continuing POA – for the management of your (financial) property
  - Personal Care POA (also referred to as a "Living Will") – for decisions re: your health
- Some things to consider
  - Everyone should draw up a POA years before they actually need it – perhaps consider doing so when creating/revising your Will
  - Will the person(s) so appointed agree to act ··· and can you trust them to handle, say, a "life-support" decision affecting you and/or your Spouse?

ESTATE PLANNING [inc. WILLS]

It is not only the wealthy who should take the time to draw up such a document; and by not having one you give up the right to choose your Estate's Beneficiaries, make gifts to close friends, name an Executor of your Estate and/or designate a guardian for your children/dependents.

Moreover, your Estate might pay more in income taxes and probate fees if there is no written document to specify how your Assets are to be divided.

Definitions

- **Estate** – The Personal and Real property of a person (the "Testator"); and the Net Value of an Estate is the value following the payment of all charges, debts, funeral expenses, administration and probate fees;
- **Executor** – The person charged with executing your wishes, as specified in your Will;
- **Intestate** – Dying without having made a Will;

- **Issue** – Includes all lineal descendants of the ancestor;
- **Probate** (Court) – A specialized Provincial Court designed to handle the management of Wills, Estates without Wills etc.

Common questions

1. **Are hand-written / pre-printed Wills valid?** Yes – if they contain the required provisions, comply with the Wills Act and are signed by the testator and two valid witnesses.

2. **Do all Wills have to be witnessed?** Yes – but neither the Executor nor a Beneficiary should be one of these witnesses [unless the Executor is neither a Beneficiary nor married to one]. Moreover, if a Beneficiary does act as a witness, then any gift to that person [and/or to the Beneficiary's Spouse] is deemed to be invalid.

3. **Can a Will be changed?** Yes – but a separate document [a "codicil"] is then signed, witnessed (x 2) and appended to the original document.

4. **How often should I review my Will?** Usually at least every 4–5 years; but more frequently as circumstances dictate.

5. **If my Will has already been prepared** and **my marital status changes, what do I do?** Your original Will is automatically revoked when you marry– unless it contains wording to the effect that it was drafted with marriage in mind. However, on divorce, the situation regarding an already-written Will is more complicated and legal advice should be sought to ensure that all parties' rights are protected.

6. **If no Will exists (i.e. if the person dies "intestate") or the Will is declared "invalid" – what happens?** You should refer to http://www.bclaws.ca/civix/document/id/complete/statreg/09013_01 for guidance under the provisions of BC's Estate Administration Act.

In general, in situations of intestacy, the Spouse and children (i.e. the "Issue") share the Estate. However, in their absence, the Estate will then go to the grandchildren, if any. Furthermore, If there are none of the afore-mentioned, the Estate then goes to the parents followed in line by the nearest relatives.

Common scenarios re the allocation of a person's Estate are as follows

A. Intestate leaving Spouse but no Issue
   – The person's Estate goes to the Spouse.

B. Intestate leaving Issue
   – Subject to the rights of a Spouse (if any), the person's Estate will be allocated to his/her Issue on a "per stirpes" basis [i.e. on the basis of "right of representation"].

C. Intestate leaving Spouse and Issue
   –If the Net Value of the Estate is <u>less than</u> $65,000 – the Estate goes to the Spouse.
   –If the Net Value is <u>greater than</u> $65,000 – the Spouse gets $65,000
   AND
   –The <u>Excess</u> is then divided as follows –
   – 50.00% goes to the Spouse (if there is a Spouse and one Child);
   – 33.33% goes to the Spouse (if there is more than one Child).

Life Insurance and Pension Plan Death Benefits
By designating specific and separate Beneficiaries under these arrangements – and indeed under specific individual Insurance Policies and Plans such as RRSPs that you may also have – you can ensure that distributions to the named Beneficiaries are <u>not</u> affected by any disputes and/or undue delays regarding the distribution of your Estate.

TO DO ASAP

- Choose the Executor of your Estate NOW.
- Consider choosing your Beneficiaries for Insurance/Pension/RRSPs NOW.
- Choose your dependents' guardians NOW.
- Choose who should receive your Assets (in the most tax-advantageous fashion) after your death.
- Consider consulting a lawyer and/or review helpful materials offered by the BC Branch of the Canadian Bar Association at: Vancouver (604) 687-4680, Toll-Free 1-(800) 565-5297 or through www.dialalaw.org