



AUTHORIZATION TO RELEASE BENEFITS INFORMATION
CUPE Education Workers' Benefits Trust

I _____, hereby direct and authorize employees of the Board of Trustees of the CUPE Education Workers' Benefits Trust, ("CUPE EWBT") to communicate with my representatives, CUPE LOCAL _____, any and all information concerning my eligibility and coverage for:

- a. health and dental benefits under Canada Life Policy 50210;
- b. life insurance and global medical assistance under Canada Life Policy 172510; and
- c. optional life insurance under Canada Life Policy 172511.

I also authorize the CUPE EWBT to receive from CUPE LOCAL _____, and send to CUPE LOCAL _____, where necessary, copies of any and all documentation of my coverage noted above.

I acknowledge further that the above-noted direction and authorization may be construed as my full and valid consent to the use or disclosure of "personal information" and "personal health information" within the meaning of the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c.5, until such time as my consent to the CUPE EWBT is withdrawn in writing.

Name: _____

OTIP #: _____

Signature: _____

Date: _____