

**MEMBER INFORMATION**

Member Last Name:		Member First Name:		Certificate / SIN Number:	
Address:		Apt.	City:	Province:	Postal Code:
Phone:	Fax:	E-mail:			
<input type="checkbox"/> Change of Address (Include written confirmation of address, including previous address)					

**BANK INFORMATION**

Name of Financial Institution:

Street Address:		Unit/Floor:	City:	Province:	Postal Code:
Phone:	Fax:	E-mail:			

**\*\*\* A VOIDED CHEQUE IS REQUIRED \*\*\***

**APPLICATIONS SUBMITTED WITHOUT A VOIDED CHEQUE WILL BE RETURNED**

**AUTHORIZATION**

I, \_\_\_\_\_ (Member's Name) hereby authorize and direct Ellement Consulting Group to have payment for my processed claims electronically deposited in my bank account of which details appear on the attached voided cheque and the financial institution named above. This authorization is to remain in full force and effect until Ellement Consulting Group has received written authorization from me of its termination or change in such time and manner as to give Ellement Consulting Group a reasonable opportunity to act on it.

The banking information submitted on this form will be used by ECG solely for the purposes of facilitating Electronic Funds Transfer payments. In accordance with the authorization provided above, ECG will use this method for any and all eligible claims and/or payments made on behalf of ECG in respect to any and all payees.

I understand that Ellement Consulting Group has no further obligation with regard to the benefits paid in accordance with this request. I also understand that Ellement Consulting Group can, without prior notice, terminate the direct deposit of benefits and issue cheques to me. Also, I grant Ellement Consulting Group the right to correct any credit entries resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

**Privacy Statement:** Ellement Consulting Group will collect, maintain and communicate only the personal information considered necessary for the administration of the plan. Personal information will be protected pursuant to the relevant legislation. The plan may use and exchange information with the relevant persons and/or organizations (Institutions, Investigating Agencies, the Union, Trustees, Insurers, Re-Insurers, Auditors, and Regulators) in order to manage the plan and entitlement to the benefits of the plan. Questions related to the privacy policy should be directed to the Fund Office.

\_\_\_\_\_  
Member Name (Please Print)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
City, Province

Please mail form with a voided cheque to:

**Ellement Consulting Group**

10154 – 108 St NW

Edmonton, AB, T5J 1L3