LABORERS' PENSION FUND OF WESTERN CANADA

CRA #0371237 Plan #42162

Claimant's Statement for Disability Pension

Please print and be sure to sign and date the statement. Mail the completed application and supporting documents to the fund office at the address at the end of this form. Please note, this form must be sworn before a Commissioner for Oaths.

Member Information

Name (Last)	(First)	(Middle)	Sex	
			M	F

Address (mailing)	Suite No.

City	Province	Postal Code	Telephone Number

Date of Birth	MM	DD	YY	Local Union No.		Social Insurance Number	

Member Statements

What is the date you last worked In Covered Employment under the Laborers' Pension Fund Of Western Canada?	Month/Year

Have you applied for Canada Pension Plan disability benefits?	Yes	No
Are you receiving Canada Pension Plan disability benefits?	Yes	No

If you have not applied or have been rejected for Canada Pension Plan (CPP) disability benefits, please indicate the reason. (CPP may be consulted for confirmation.) Please note, eligibility for CPP disability benefits does not automatically entitle you to disability benefit from the Laborers' Pension Fund of Western Canada.

Have you applied for any other disability benefits (i.e. Workers' Compensation, Employment Insurance, private, or provincial)?	Yes	No

If you have not applied or have been rejected for any applicable disability benefits, please indicate the reason.

If you are applying more than 6 months after the date you became disabled, indicated the reason for the delay.

Are you currently employed?	Yes	No
Are you currently seeking employment?	Yes	No

If yes, indicate what kind of employment. Please note, verification from your annual Income Tax Return may be required.

COMPLETE REVERSE SIDE AS WELL

Member Declaration

I hereby apply for a disability pension from the Laborers' Pension Fund of Western Canada. The statements made in this application are complete, true, and correctly recorded to the best of my knowledge and belief. I understand a false, misleading or inaccurate statement shall be sufficient reason for the denial, suspension or discontinuance of benefits under the pension plan and the Trustees shall have the right to recover any payments made to me because of a false, misleading or inaccurate statement.

I understand, to be eligible, the member must be completely unable, due to physical or mental impairment, to engage in any and every gainful occupation for which he/she is reasonably fitted by education, training or experience, and such disability must be permanent and continuous for the remainder of his/her life, as per the Income Tax Act and the Rules and Regulations of the Laborers' Pension Fund of Western Canada. I understand, to be eligible, the member must also be an active participant or a former participant with a life expectancy of less than 2 years.

I expressly consent, authorize, and direct every physician, surgeon or any other person who has examined me, every hospital or other institution in which I have received treatment, and every other plan, including the Workers' Compensation Board, to which I have applied, to disclose to the Laborers' Pension Fund of Western Canada, any knowledge or information thereby acquired. I also consent to the Laborers' Pension Fund of Western Canada providing information from my disability pension application to third-party consultants, such as Homewood Health Inc., for the purposes of evaluation of my application.

I understand, I may be required to provide, upon request of the Laborers' Pension Fund of Western Canada, a complete copy of my latest annual Income Tax Return to verify I continue to meet the criteria to be eligible for receipt of a disability pension. Further, if I do not provide a copy of my latest annual Income Tax Return and the Notice of Assessment from Canada Revenue Agency, and such other reasonable information as may be required, the Laborers' Pension Fund of Western Canada may suspend the payment of further disability pension payments to me.

I make this application and declaration conscientiously believing it to be true and knowing it is of the same force and effect as if made under oath and by virtue of the Canada Evidence Act.

DECLARED BEFORE ME in the _____)

of _____ , in the Province)

of _____ , this _____ day)

of _____ , 20 _____)
)
_____)
A COMMISSIONER FOR OATHS in and)
for the Province of _____)

_____
Member's Signature

_____
Name of Commissioner (Please Print)

_____
Expiry Date of Commissioner

You will be notified in writing of the decision made by the Board of Trustees regarding your application or if any additional information is required.

Please return this form, with your original signature to:

Ellement Consulting Group
1050-11150 Jasper Ave NW
Edmonton AB T5K 0C7

Phone: 780-453-2303 Toll Free: 1-800-661-7369 Email: laborers@ellement.ca