CLEAR FORM

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Authorization to Collect, Use & Disclose Personal Information

Employee Name: _____ _____ _____
Last name First name Middle initial

Employee SIN: _____
For identification purposes

I understand that:

- Personal information and personal health information will be collected from me for the purpose of administering the Healthcare Employees' Pension Plan - Manitoba (HEPP) and the Healthcare Employees' Benefits Plan - Manitoba (HEBP), which includes the Healthcare, Life Insurance, Dental, Disability & Rehabilitation, and Retiree Healthcare Plans. This includes enrolling members, appointing beneficiaries, determining my eligibility and entitlement, if any, to benefits, and processing my benefits, if any (hereinafter, the "Identified Purpose").
- For the Identified Purpose, it may be necessary to collect my personal information and personal health information from and disclose my personal information and personal health information to individuals and organizations acting on behalf of HEPP and HEBP, such as: *staff of HEPP and HEBP; actuaries; lawyers and physicians, as well as other individuals and entities, such as my physicians, my employer(s), my healthcare providers, other insurers and government regulators.*
- The privacy of individuals about whom the information relates and the confidentiality of personal information collected will be protected in accordance with relevant privacy policies and privacy law(s).
- I may withdraw all or part of my consent at any time, in writing, but that doing so may interfere with fulfilling the Identified Purpose and may result in a delay in processing my application for benefits or may result in my benefits being declined, in whole or in part.

I, _____ (please print name) **authorize the administrator(s) of HEPP and HEBP, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the Identified Purpose. A reproduction of this authorization is as valid as the original.**

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Please see www.hebmanitoba.ca/privacy for more information about privacy at HEB Manitoba.

Form Return

Please return the completed form to the representative in your facility/RHA responsible for benefits, e.g., the Human Resources or Payroll Department. Your employer representative will submit your form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB R3C 4L5.