

# Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan

## REQUEST FOR FREEZING OF HOURS

SECTION 1	<b>Member Information</b>		Local Union No							
	Name (Last)		(First)			Sex (please circle)		Date of Birth		
						M      F		M      D      Y		
	Address (Street)		Social Insurance Number							
City		Prov	Postal Code			Telephone Number				

### Please complete appropriate box below

SECTION 2	<b>Request for Worker's Compensation Freezing</b>					
	Please be advised that I, _____, the undersigned participant of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan, have received payment from Workers' Compensation Benefits for the period:					
	Start Date		End Date		<b>Note: Copies of paystubs indicating payment for a minimum of 14 days per month must be submitted with request</b>	
	M      D      Y		M      D      Y			
If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated above, up to the maximum period permitted in the Eligibility Rules.						

SECTION 3	<b>Request for EI Sickness and Accident Freezing</b>					
	Please be advised that I, _____, the undersigned participant of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan, have received payment from Unemployment Insurance Benefits for the period:					
	Start Date		End Date		<b>Note: Copies of paystubs indicating payment for a minimum of 14 days per month must be submitted with request</b>	
	M      D      Y		M      D      Y			
If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated above, up to the maximum period permitted in the Eligibility Rules.						

SECTION 4	<b>Request for Trade School Freezing</b>					
	Please be advised that I, _____, the undersigned participant of the Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan, attended Trade School during the following period:					
	Start Date		End Date		If I am Eligible, I understand that my reserve account of hours will be frozen for the period indicated above, up to the maximum period permitted in the Eligibility Rules.	
	M      D      Y		M      D      Y			

SECTION 5	I declare that the statements I have made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided.					
	Signature			Date		

**TRUSTEE APPROVAL CONFIRMED: Date**

**Signature**

Please return to:  
**FAS Benefit Administrators Ltd.**  
 9<sup>th</sup> floor, 9707 - 110 Street  
 Edmonton, AB T5K 3T4

Phone (780) 452-5161  
 Toll Free 1-800-770-2998

**Fund Office Use Only**

Freezing Code: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Month: \_\_\_\_\_ Initials: \_\_\_\_\_