HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

HEB Manitoba Use Only

Disability & Rehabilitation Plan
Appeal Process: Member Agreement and Acknowledgement

SECTION 1: MEMBER INFORMATION

Member Name: _____

Claim ID:_____HEB ID: _____

SECTION 2: AGREEMENT AND ACKNOWLEDGEMENT

I agree and acknowledge that I have received and reviewed a copy of the Healthcare Employees' Benefits Plan (HEBP) Disability and Rehabilitation (D&R) Plan Claim Review Process (the Claim Process), Terms of Reference for Appeal Hearing (the Appeal Process) and HEBP Disability and Rehabilitation Plan (the HEBP D&R Plan);

I understand and agree that the Appeal Hearing will apply to my appeal of a decision to deny or discontinue Disability Benefits under the HEBP Disability and Rehabilitation Plan (the HEBP D&R Plan);

I further understand and agree that the evidence to be considered on the Appeal will be limited to the information and documents contained in the file maintained by HEBP in regards to my claim for benefits pursuant to the HEBP D&R Plan as it exists at the date of the final adjudication of the decision which is the subject of this appeal, the HEBP D&R Plan, the Claim Process, the Appeal Process, and this Member Agreement and Acknowledgement;

I acknowledge and agree that I have had the opportunity to review HEBP's file in regards to my claim for benefits as it exists at the date of the final adjudication of the decision which is the subject of this appeal;

I understand and agree that no further evidence can be filed for consideration on this appeal;

I further understand and agree that if I elect to proceed with an oral hearing, any oral testimony given will be limited to the facts and matters contained in the documents in HEBP's file in regards to my claim for benefits;

I further acknowledge and agree that if I elect to proceed with an oral hearing that HEBP shall have the right to determine the location of the hearing of the appeal;

I hereby acknowledge and agree that by commencing an Appeal Hearing under the Appeal Process, and entering into this written agreement with the Healthcare Employees' Benefits Plan (HEBP), I am confirming that the Appeal Hearing constitutes a final and binding arbitration of my entitlement to receive, or continue to receive, Disability Benefits pursuant to the terms of the HEBP D&R Plan;

I further acknowledge and agree that I, and HEBP, are bound by the decision of the Appeal Hearing that is constituted pursuant to the Appeal Process, and that I am forever foregoing any right or entitlement to commence or continue any legal or other action, pursuant to the HEBP D&R Plan, legislation or otherwise, subject only to the review provisions under The Arbitrations Act (Manitoba);

I hereby certify that, prior to signing this Agreement and Acknowledgment, I have had the opportunity to seek independent legal advice with respect to the effect of this Agreement and Acknowledgment;

I further certify that I am signing this Agreement and Acknowledgment voluntarily and without duress, coercion or compulsion of any kind

Member Name: _____

Member Signature: _____ Date Signed: _____ _____ _____
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SECTION 3: HEALTHCARE EMPLOYEES' BENEFITS PLAN

To be completed by HEBP.

Name: _____ Title: _____

I have the authority to bind HEBP

Signature: _____ Date Signed: _____ _____ _____

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