INDIVIDUAL'S CONSENT TO DISCLOSURE OF PERSONAL INFORMATION

I, _____, date of birth _____ residing at
(name of individual)

_____
(full address)

_____, Telephone no: _____

do hereby authorize WorkSafeBC (the Workers' Compensation Board of BC) to disclose my personal information from the following records :

_____

_____
*(**identify records, e.g. WorkSafeBC Claim number or any type of records**)*

to: the BCTF Salary Indemnity Plan;

BC Teachers' Federation - ISD, 100 - 550 W 6th Ave, Vancouver, BC V5Z 4P2
*(**specify name and address of the body or person authorized to receive and/or use this information**)*

to be used for the purpose of: administration of the claimant's disability benefit plan.

_____

I certify that I am 19 years of age or over**.**

This consent shall be and remain in effect for **2 years** unless otherwise specified or revoked in writing prior to that date*.*

_____ _____
(signature of individual giving consent) *(date signed)*

For further information about the collection, use or disclosure of personal information, please contact WorkSafeBC's Freedom of Information Office at PO Box 2310 Stn Terminal, Vancouver, BC V6B 3W5, or telephone 604.279.8171. Fax: 604.279.7401