THE UNIVERSITY OF BRITISH COLUMBIA

INCOME REPLACEMENT PLAN – FACULTY ENROLLMENT FORM

Personal information provided on this form is collected pursuant to section 26 of the *Freedom of Information and Protection of Privacy Act,* RSBC 1996, c. 165 (FIPPA) for the purpose of benefits administration, claims submission and to make any necessary payroll deductions. The information will be used, retained & disclosed by UBC in accordance with FIPPA. For further information, please email benefitsinfo@hr.ubc.ca.

Name of Employee (first name, last name)	Employee Identification Number	Department

I hereby apply for the Income Replacement Plan (Long Term Disability). I understand that participation in the Income Replacement Plan is mandatory and that I will be enrolled automatically, effective on my date of hire and premiums will be deducted, as necessary.

Signature **Date**

FOR OFFICE USE ONLY	
Effective Date	Employee ID