CUPE 3903 Application for Extended Health Reimbursement Fund
Option B – Foreseeable/Planned Needs
Deadlines: January 10th, May 10th, September 10th

This application information is kept confidential. Submit application, pages 1 & 2, in a sealed envelope marked "**personal and confidential**" and address to: CUPE 3903 Extended Health Reimbursement Fund, TEL 2050, York University. 4700, Keele St., Toronto Ontario, Canada, M3J 1P3**.**

Member Name:	**Phone:**
Email:	**Date of application:**
Address: (where a cheque, if issued, will be sent)	**Date of most recent CUPE 3903 contract** _____ Circle the deadline for which you are applying Sept Jan May
Check the boxes that apply to you ☐ **International student** ☐ **Single person with dependents**	**Questions? Email ehb3903@gmail.com**

Total Foreseeable Personal Health Costs Requested for the following four month period**:** $_____

The application must contain estimates of costs to be incurred. Estimates can include past receipts for the health product, a letter from a health professional with estimated costs , or an advertised price for an assistive device.

Income:

Annual income (from all sources) after taxes	
Partner's annual income (if applicable) from all sources after taxes	
Total	$

Option B offers members the opportunity to self-identify where issues like racism, homophobia, sexism, class and ability biases are directly connected with the health issue they are trying to address. The purpose of voluntary self-identification is to offer the possibility of priority access to Option B fund. If you find it appropriate and relevant, please note on a separate piece of paper any forms of social marginalization that you experience and how they affect the current health needs that you are trying to meet with this application.

Monthly expenses:

Item		Amount
Rent/mortgage		
Heat		
Utilities		
Food		
Transportation		
Miscellaneous: Please list		
	Total Monthly Costs	$

IMPORTANT: It is not necessary but if you wish to, please attach a statement with an explanation of the extended health care need for which funding is being requested and include any additional supporting documentation. The statement shall also explain how the cost will present an undue financial burden.

I certify that all information presented herein is accurate to the best of my knowledge. Signature
Date:

This space is for use of EHB Committee only

Outcome of application:

1. All costs approved at _____ % ; $ _____ cheque to be issued
2. Partial costs approved at _____%; $ _____ cheque to be issued
3. Rejected because _____

Circle reason(s) for partial cost approval

a. Ineligible expenses ☐ b. More info needed for a particular request ☐

Brief Explanation of a and/or b: _____

_____

_____

Signature of EHB Members (each application is double read)

1. _____

2._____

CUPE 3903
Extended Health Benefits Fund Allocation Policy

Approved by the membership:

Preamble

The Extended Health Benefits Fund (EHBF) is collectively bargained by and for CUPE 3903 members in Units 1, 2 and 3. The agreed to amounts are provided to the union by the employer for each September to August Collective Agreement year at the start of it. The Extended Health Benefits Committee (EHBC) is a group of members elected annually at a General Members Meeting. Their role is to adjudicate applications. The equity officer serves on the committee ex-officio.

The purpose of the EHBF is to support members with health care costs that would cause an undue financial burden and that are not covered by the Sun Life Insurance plan. In setting up the policy, guidelines and allocation process for the EHBF the union recognizes that there is a strong relationship between a range of social factors and a person's health and well-being. Such social determinants of health include, but are not limited to: income, social support, education and literacy, employment and working conditions, housing, health services, nutrition and coping skills. The union also recognizes that inequitable access to resources and supports may be specific and/or systemic. People may have a lack of access due to poverty and they may be denied access due to one or more forms of social exclusion (such as racism, sexism, ableism heterosexism and transphobia). Health issues and health inequities are thus often deeply intertwined.

This understanding also incorporates the fact that there is a finite amount of money in the Fund for a growing union membership of approximately 3400. Ongoing collective bargaining is critical to continuing to improve member access to funds to support them with health care expenses.

Role of the Extended Health Benefits Committee

The EHBC's collective role is to give equitable access to and allocation of a finite amount of funds in each Collective Agreement year to members of CUPE 3903 as per this policy. The EHBC members sign a confidentiality agreement at the start of their term. The committee makes decisions based on all the guidelines set out below in the policy. Committee members do not deliberate on their own EHB applications.

Fund Types, Funding Periods and Budget

There are two fund types: Option A for extended health care needs that are **unexpected** and **urgent** that present an undue financial burden and Option B for extended health care needs that are **foreseeable** or **planned** that present an undue financial burden. Option A claims are adjudicated on a monthly basis. Option B claims are made on a going forward basis and adjudicated three times a year, with application deadlines of September 10, January 10 and May 10.

There are three funding periods each year. The $100,000 in the Fund for the 2010-2011 year will be allocated as follows:

	Sept 10 to Jan 9	Jan 10 to May 9	May 10 to Sept 9
Option A (40%)	13,400	13,400	13,200
Option B (60%)	20,100	20,100	19,800
Total: $100,000	33,500	33,500	33,000

At the end of each Collective Agreement year the EHBC will update this budget for membership approval to reflect the coming year's funds.

Allocation Guidelines

The following guidelines are used in the application review and fund allocation process. They include basic eligibility requirements, factors assessed for equitable disbursement and eligible expenses.

Basic Eligibility:

- Due to the limited availability of funds, access to the fund is restricted to members only, not their family members or dependants. The exception is with reproductive technologies.
- Health care expenses made during a Collective Agreement year will only be reimbursed during that year.
- EHBF member eligibility follows Sun Life insurance plan eligibility. Thus members may make claims for four months after the date of their last contract, as long as the expense made or proposed is in the Collective Agreement year in which the member applies.
- Generally Option A expenses will only be considered in the funding period in which they are incurred.
- All applications must be fully completed in order to be considered.

Equitable Disbursement Factors:

- Members may apply as many times as they wish in a year.
- After the first funding period, priority will be given to first time applicants that year.
- Consideration will be given to members who have international student status and/or who are single people with dependents.
- Option B applicants have the opportunity to identify in an equity statement any form of social marginalization they experience (for example, as a result of race, ethnicity, class, sexual orientation, ability, etc.) and how this affects the needs they are trying to meet with the application.
- Approved applicants will ***generally*** receive between 25% and 50% of the costs applied for.
- As this is a financial needs based fund, the committee may follow up with members whose net income appears large in comparison to the EHB amount being requested.

Eligible Expenses:

Support from this fund might range from the one time purchase of an assistive device to an ongoing regiment of therapy or to unexpected health needs resulting from a sudden accident or injury. This includes assistance with costs associated with longer-term disabilities and/or care

needs that are **not** otherwise covered by under other health insurance plans. Cosmetic procedures are not covered. *In addition*, the following is covered:

- Non-MD psychotherapy
- Travel health insurance (does not include baggage or cancellation insurance)
- Acupuncture
- Orthotics (with a doctor's note)
- Vision care expenses, once the regular plan coverage is exhausted (proof of exhaustion required)
- Emergency dental work, once the regular plan coverage is exhausted (proof of exhaustion required)
- Prescription drugs after coverage is spent, once the regular plan coverage is exhausted (proof of exhaustion required)
- Naturopathy, Chiropractic, Physiotherapy, Psychologist, Podiatry and Massage Therapy (this last one with a doctor's note within the last year) once the regular plan coverage is exhausted (proof of exhaustion required)
- Incidental health expenses (e.g. hospital parking, emergency taxis, crutches/canes, etc.)
- Other services de-listed from OHIP

Appeals

When a member notifies the committee that they wish to appeal a committee decision on their application, the member's application will be reviewed by one committee member, one designated executive member and the Equity Officer (ex-officio).

To be considered the appeal must be submitted within one month of the member's receipt of the committee's original decision.

Application Forms

There are two application forms, Option A and Option B. They are attached as part of this policy.