# U.A. LOCAL 787 BENEFIT PLANS
# MEMBER INFORMATION FORM

**IMPORTANT NOTE**: Please fill out this form completely. The information provided on this form will replace information provided on all earlier Member Information Forms or Enrolment Forms. You must notify us of any changes to the information below.

## MEMBER'S PERSONAL INFORMATION

Legal Name: _____ (Last Name) _____ (Given Names) SIN: _____

Address: _____ (Number/Street/Apt. Number) _____ (City) _____ (Province) _____ (Postal Code)

Date of Birth: _____ (mm/dd/yyyy) Phone: _____ Email: _____

Gender: ☐ Male ☐ Female ☐ Other

**Please indicate your current Marital Status. Select one option.**

Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Divorced ☐ Widowed ☐ Separated _____ (Date of Separation)

## MARITAL STATUS

If you are married, please provide date of marriage: _____

If you are in a Common-Law relationship, please complete the following statement:

I do hereby declare that _____ (spouse's name – please print) is my Common-Law Spouse with whom I have been cohabitating since: _____ (date cohabitation commenced) and whom I publicly represent as my Spouse.

**This signature is only required if member is in a Common-Law relationship.**

Member's Signature: _____

## PERSONAL INFORMATION ABOUT MEMBER'S DEPENDANTS – INCLUDING SPOUSE

Please list Dependants for health benefit coverage below. Common-law spouses are eligible for health benefits after living together with the member for 12 consecutive months in a conjugal relationship.

**Please list your spouse and dependant children under the age of 21, or under the age of 26 if in attendance at an accredited school. Child dependants over the age of 21 incapable of self-support may also be covered**

| NAME | | | DATE OF BIRTH | | | GENDER | RELATIONSHIP |
|---|---|---|---|---|---|---|---|
| LAST | FIRST | MIDDLE | MONTH | DAY | YEAR | | |
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## COORDINATION OF BENEFITS

**If you or your spouse/dependants are covered under any other benefit plan, please provide the information here.**

Is benefit coverage available to you and/or dependants from another plan(s)? ☐ Yes ☐ No

Name of Policyholder: _____ Relationship to Policyholder: _____ (ie: spouse, ex-spouse, stepparent/guardian to my dependants)

**Does the other benefit plan provide coverage for your whole family or just the individual listed?**

Name of other plan(s): _____

☐ Family Coverage ☐ Single Coverage

Coverage for: ☐ Prescriptions ☐ Vision ☐ Dental ☐ Major Medical ☐ Hospital

**COMPLETE BOTH SIDES AND RETURN TO THE BENEFIT ADMINISTRATION OFFICE**

45 McIntosh Drive, Markham, ON, L3R 8C7

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**If you need more space to add beneficiaries, please add an attachment, and check this box to confirm you've added an attachment** ☐

**The person(s) named as your Health Beneficiary will be the recipient of your life insurance payment (if applicable).**

## HEALTH PLAN BENEFICIARY – U.A. LOCAL 787 HEALTH FUND

***Life Insurance and Accidental Death and Dismemberment***

First and Last Name: _____ Relationship: _____

Phone: _____ Email: _____

Check this box if the above name is an irrevocable beneficiary ☐ If the above beneficiary(ies) predeceases me, my contingent beneficiary is:

_____

Full Name | Relationship | Phone | Email

_____

Full Name | Relationship | Phone | Email

If your original and contingent beneficiary(ies) predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

**If your employer is participating in the Pension Plan, please complete this section**.

## PENSION PLAN BENEFICIARY – U.A. LOCAL 787 PENSION FUND

Pension Plan Registration Number: 0491688

First and Last Name: _____ Relationship: _____

Phone: _____ Email: _____

Check this box if the above name is an irrevocable beneficiary ☐ If the above beneficiary(ies) predeceases me, my contingent beneficiary is:

_____

Name | Relationship | Phone | Email

_____

Name | Relationship | Phone | Email

If your original and contingent beneficiary(ies) predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate. In the event of your death, prior to your retirement, your spouse (or common-law spouse if cohabitated for 3 years) is automatically the first person eligible to receive a pension benefit unless a spousal waiver is on file, no matter who you designate as a beneficiary. Your beneficiary will become eligible for benefits only if you do not have a spouse on your date of death.

Caution: Your designation of a beneficiary by means of the Member Information Form will not be revoked or changed automatically by any future event (including marriage or divorce) unless required by law or regulation. Should you wish to change your beneficiary, you must do so by completing a new Member Information Form.

**If your employer is participating in the Vacation Pay Plan, please complete this section**. The person(s) named as your Vacation Pay beneficiary will be the recipient of your Vacation Pay payment (if applicable)

## VACATION PAY BENEFICIARY – U.A. LOCAL 787 VACATION PAY FUND (IF APPLICABLE)

First and Last Name: _____ Relationship: _____

Phone: _____ Email: _____

Check this box if the above name is an irrevocable beneficiary ☐ If the above beneficiary(ies) predeceases me, my contingent beneficiary is:

_____

Name | Relationship | Phone | Email

_____

Name | Relationship | Phone | Email

If your original and contingent beneficiary(ies) predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

**The person named as a Trustee will receive any benefits payable on behalf of your beneficiary(ies), if they are under the age of majority at the time of your death (not applicable in Quebec).**

## APPOINTMENT OF TRUSTEE – FOR MINOR CHILDREN

I hereby appoint the person listed below as a Trustee to receive any amount(s) payable to any beneficiary under the Age of Majority

First and Last Name: _____ Relationship: _____

Phone: _____ Email: _____

## CONSENT AND COMPLETION

By signing below, I hereby certify that the information provided is true to the best of my knowledge, and consent to the collection, maintenance, use and disclosure of my personal information as described in the Privacy Statement below. I acknowledge that providing my consent will allow access to the information required to assess my benefit eligibility and entitlement, and that refusing to consent may result in delay or denial of my request and/or benefit. This consent may be revoked by me at any time by sending written instructions to the Benefit Administration Office.

**This form requires a witness who is not your spouse or beneficiary to sign where indicated. Please ensure that your signature is witnessed by someone other than your Spouse or Beneficiary.**

Signature and Consent: _____ Date: _____

Witness Signature: _____ Witness Name (Print): _____

**Privacy Statement:** The Plans will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plans. Personal Information will be protected pursuant to the applicable legislation. The Plans may use and exchange information with relevant persons and organizations including the Trustees, institutions, investigative agencies, unions, insurers, re-insurers, auditors, legal counsel, actuaries, payroll/payment providers, Plan administrators, and regulatory authorities in order to manage the Plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.

**COMPLETE <u>BOTH</u> SIDES AND RETURN TO THE BENEFIT ADMINISTRATION OFFICE**

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