APPLICATION FOR THE U.A. LOCAL 787 RETIRED MEMBER HEALTH PLAN
(The "Health Plan")

Legal Name:	**Social Insurance Number:**
Address:	
Phone Number:	**Date of Birth:**
Last Date Worked:	
Requested date of Retired Member Health Plan Coverage:	

MEMBER DECLARATION AND CERTIFICATION

I understand that it is my responsibility to advise the Health Plan Administrator in writing, of any changes with respect to the status of my Spouse, or Dependents, and to make any necessary re-designation of Beneficiary.

I understand that the personal information that I provide in this Application is collected for the purpose of administering the Health Plan. I understand that my social insurance number will be used only as an identifier for record keeping and for the administration of the Health Plan. I hereby consent to the collection of the personal information that I provide on this form, including my social insurance number, and authorize the Health Plan, the Health Trust Fund, the Health Plan Administrator, and the Board of Trustees to use and disclose my personal information to their employees and staff, and their professional advisors or agents, including an insurance company, and other parties, solely for the purposes of administering the Health Plan, record keeping, and as required by law.

I hereby certify that:

1. As of the date noted above, you satisfy U.A. Local 787 that you have retired from the "HVACR Industry" as defined below, both union and non-union and you are and remain a Member in Good Standing of U.A. Local in accordance with the U.A. Constitution & U.A. Local 787 By-laws;

2. You have ceased to work for, or be available to work for a Contributing Employer, you do not have Employer Contributions being made on your behalf during WSIB (i.e. Workers' Compensation) benefit receipt, you are not receiving LTD benefit payments (or do not have an application in process for such Benefits, unless you have elected RMHP coverage under the Disabled Member Plan provisions);

3. Under the Health Plan, "HVACR Industry" means;
    a) Paid work covered by any collective agreement of U.A. Local 787 or any similar local of the U.A.;
    b) Paid work either as an employee or on a self-employed basis of any kind for any participating employer in the Health Fund or an affiliated company or entity or any work for a competitor of such participating employer or affiliated company or;
    c) Paid work for any entity that competes with U.A. Local 787 or any related entity of U.A. Local 787 including the Joint Training and Apprenticeship Committee (J.T.A.C.);

4. I understand that I am considered to be eligible for the U.A. Local 787 Retired Member Health Plan including, Major Medical (excluding Emergency Travel Assistance Benefits), Dental, and Life Insurance coverage, if I meet the eligibility conditions as at my **Retirement date**.

PLEASE READ & COMPLETE ALL PAGES - INCOMPLETE FORMS WILL BE RETURNED

5. I understand and agree that in order for my Retired Member Health Plan coverage to continue in future, I must:
    a) Continue to be a member in good standing of U.A. Local 787 in accordance with the U.A. Constitution and U.A. Local 787 By-Laws on a continuous basis from the date I become a Retired Member;
    b) Confirm, on each claim form submitted to the Administrator, whether I (or my Dependent, if applicable) am covered by another group health benefit plan; and, if applicable, I must pay direct for my Retired Member coverage on a continuous basis after my **Retirement Date**; and my coverage cannot be reinstated;

6. I further understand and agree that:

    a) I will be immediately disqualified for Retired Member coverage if I work in the "HVACR Industry" (as defined in the U.A. Constitution and U.A. Local 787 By-Laws) for a non-union employer, or as a non-union employer (owner operator),
    b) Once disqualified that I will never be eligible for Retired Member Health Plan coverage again, and that the Board of Trustees reserves the right to recover any claims paid that are incurred following the date I commence work in the trade for a non-union employer, or as a non-union employer; and
    c) If I return to covered employment for a participating employer who is making contributions to the Health Plan after receiving RMHP benefits, I shall continue to receive RMHP benefits but shall receive no other benefits from the Health Plan as a result of such employer contributions;
    d) If I am otherwise eligible for RMHP coverage but am employed by any U.A. union entity affiliated with the AFL-CIO or the CLC that does not compete with U.A. Local 787, such person's right to obtain RMHP benefits shall be postponed and my account in the Health Fund will be suspended until such time as such person has ceased all employment with such union entity or entities and otherwise remains eligible for RMHP.
    e) I understand that my Retire Member coverage will be suspended if I return to work after my **Retirement Date**. I understand that suspended for the purpose of this provision means that my coverage will be terminated during the period that I am working in the stated post-retirement employment and that my coverage will not be extended for the duration of the time I work in post-retirement employment.

7. I acknowledge that the Board of Trustees has the right to terminate or amend the Health Plan, at any time, at its sole discretion, without advance notice.

8. I hereby agree to abide by and comply with each and every term, condition and requirement summarized in the Health Plan Booklet.

Dated this _____ day of _____

_____ _____

Signature of Witness Legal Signature of Member

U.A. Local 787 will be required to certify that you are a member in good standing of U.A. Local 787, you are not on the U.A. Local 787 Out-of Work List, and the union is satisfied that you have retired from the trade, both union and non-union.

THIS FORM IS A LEGAL DOCUMENT. PLEASE MAKE SURE IT IS FILLED OUT IN FULL, SIGNED, WITNESSED AND DATED.

RETURN FORM TO:

Employee Benefit Plan Services Ltd.

45 McIntosh Drive, Markham, Ontario L3R 8C7

info@787benefits.ca

Tel: (905) 946-2220 toll free: 1-866-946-2220

PLEASE COMPLETE AND RETURN THIS FORM

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