UA Local 67 Welfare Plan

Member and Family Enrolment/Change Form

Instructions

This is a three-page form. Please complete all three pages in full. Incomplete or inaccurate information could result in refusal of benefits or delays in the processing of your claims. Be sure to sign and date this form. Please attach a completed pension fund Appointment of Beneficiary Form, and (if applicable) a waiver of pre-retirement death benefit form and return to: Reliable Administrative Services Inc., 195 Dartnall Road, Suite 102, Hamilton, Ontario L8W 3V9. Telephone (905) 387-5861

Type of change	Effective date	Type of change	Effective date	Type of change	Effective date
☐ New member	DD / MMM / YY	☐ Add/change child	DD / MMM / YY	☐ Change beneficiary	DD / MMM / YY
☐ Add/change spouse/partner	DD / MMM / YY	☐ Spouse/partner change in coverage	DD / MMM / YY	☐ Other (specify)	DD / MMM / YY

1. Member Details

Last Name: _____ First Name: _____

Middle Name: _____ Sex: Male ☐ Female ☐

Social Insurance Number: _____ Date of Birth: _____ Day / Month / Year

Union Membership Number: _____

Complete Mailing Address: Street: _____

City/Town: _____ Province: _____ Postal Code: _____

Country (only if not Canada): _____ Phone: _____ Email: _____

If you are covered for benefits under another employer, group or association plan, please check any box that applies:

☐ hospital ☐ prescription drug ☐ dental ☐ medical ☐ vision ☐ travel

Do you have a spouse/partner *(see definition below)* who qualifies for dental, extended health and travel benefits? Yes or ☐ No ☐ *(mark one)*.
If yes, complete section 2.

2. Spouse/Partner Details *(see definition below)*

If you have an eligible spouse and leave this section blank, he or she may not be covered.

Last Name: _____ First Name: _____

Middle Name: _____ Date of Birth: _____ Day / Month / Year

Province of Residence: _____

Address, if different from yours: _____

If your spouse is covered for benefits under another employer, group or association plan, please check any box that applies:

Insurer/Name of Plan: _____ Plan#: _____ ☐ single ☐ family

☐ hospital ☐ prescription drug ☐ dental ☐ medical ☐ vision ☐ travel

Who qualifies as your spouse/partner for *dental, extended health and travel benefits*

A person who is:

- married to you, or
- not married to you and is living with you in a conjugal relationship for a minimum of one year.

3. Children *(see definition below)*

Last Name	First Name	Sex *Circle F or M*	Date of Birth *Day / Month / Year*	If over age 21 Full-time Student under age 25 *Circle Yes or No*		Disabled *Circle Yes or No*	
		F M		Yes	No	Yes	No
		F M		Yes	No	Yes	No
		F M		Yes	No	Yes	No
		F M		Yes	No	Yes	No
		F M		Yes	No	Yes	No

Address if different from yours:_____

***Important note**: If you have eligible children and do not list them above, they may not be covered.*

Who qualifies as your child for *dental, extended health and travel benefits* ?

You or your spouse's natural, legally adopted, step or foster children who are:

- unmarried, and
- dependent on you or your spouse for financial support,

and either

- under age 21, or
- A full-time student under age 25 who was covered un this plan before age 21, or *(proof of schooling is required)*
- any age and not capable of self-support because of a mental or physical disability and covered under this plan before age 21.

You may not cover children from a legal marriage at the same time as children from a common-law relationship unless they are children who live with you or who don't live with you but are fully dependent on you for financial support

If you or your spouse are covered under another health or dental plan

According to the rules established by the Canadian Life & Health Insurance Association, claims should be submitted in the following order:

1. First to any plan that does not have rules about claiming from more than one plan.
2. If both plans have rules, a member or spouse must first submit his/her own claims to his/her own employer's plan.
3. Claim for covered children from the plan covering the parent whose birthday comes earlier in the calendar year.
4. If a person is a member of two plans, claims are submitted in the following order:
   - the plan where the member is an active full-time employee,
   - the plan where the member is an active part-time employee,
   - the plan where the member is a retiree,
   - any plan where the member is covered as a dependant.

4. Beneficiary for Life Insurance *(benefits will be paid to the latest beneficiary on file with the Administrator)*

You may name anyone you choose to receive your life insurance benefits. If you do not name a beneficiary, or no named beneficiary is alive to receive your life insurance benefits, this benefit will be paid to your estate unless otherwise indicated in your will. You may change your beneficiary at any time.

Beneficiary's Last Name	First Name	Initial	Relationship	Percentage
1.				
2.				
3.				

5. Consent

I understand:

- that personal information is being collected on this form for the purpose of administering the benefit plan, which includes enrolling members and maintaining complete and accurate information;
- that it may be necessary to disclose personal information to and collect personal information from individuals and organizations, such as, the benefit plan consultant and insurers, for the identified purpose;
- that the privacy of the individuals about whom the information relates and the confidentiality of the personal information collected on this form will be protected in accordance with the relevant privacy policies and privacy law(s); and
- that I may withdraw all or part of my consent at any time, in writing, but that doing so may interfere with fulfilling the identified purpose.

I consent to the collection, use, and disclosure of my personal information, for the identified purpose, by the benefit plan's Administrator and Board of Trustees, and the individuals and organizations that are authorized to act on their behalf.

I am authorized to disclose, on this form, personal information about other individuals, such as, my spouse/partner and my children, to be used and disclosed for the identified purpose.

6. Signature

I consent to the above terms and certify that all information provided on this form is accurate and true.

Member Signature_____ Date_____
Day / Month / Year