# 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** ☐ *(check 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 at least 12 months and a) being represented as your common law spouse to the Canada Revenue Agency (copy of 1st page of the T1 General required) or b) by providing a notarized Affadavit confirming the conjugal/common law relationship.

## 3. Children *(see definition below)*

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

Dependent child(ren) must reside in Canada and be insured under a provincial Healthcare Insurance Plan and who are being reported to the Canada Revenue Agency as eligible dependents; proof of child custody and/or agreement or child tax credit may be required.

### 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.

## 4A. 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.** | | | | |

## 4B. Appointment of a Trustee for Minor Child(ren)

| Name of Trustee | Relationship | Name of Minor Beneficiary | Last Name | First Name |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## 4C. Appointment of Contingent Beneficiary(ies)

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. A Contingent Beneficiary can be named in the event of your demise and that of your primary beneficiary.

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

## 5. Consent

**I hearby** apply for coverage ("Coverage") under the Group Benefit Plans issued to Members of the UA Local 67 Trust Funds by multiple insurance companies. **I understand** certain aspects of such Coverage may extend to my spouse and eligible dependents (collectively, "Dependents"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependents, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete or misleading information.
**I authorize** UA Local 67 and their expert providers to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I am authorized** by my Dependents to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their information for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electric version of this authorization is valid.

If applicable, **I authorize** UA Local 67 through Reliable Administrative Services Inc. ("RASI") to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. **I understand** such correspondence may contain Information; and that the Information is being sent in a manner that is not guaranteed as a secured means of communication. **I agree** that RASI is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by RASI or by me pursuant to this authorization. **I agree** should the email address identified on this form change that I am responsible for updating the email address maintained by RASI. **I understand** that if I do not wish to receive emails from RASI, I can remove my email address by contacting the RASI office.

I understand that any Information provided to or collected by RASI in accordance with this authorization, will be kept in a Group Benefits Life, Health or Disability file. Access to my information will be limited to:

- RASI employees, representatives, insurers and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

**I acknowledge** that more specific details regarding how and why RASI collects, uses, maintains, and discloses my personal information can be found in RASI's Privacy Policy, available at www.reliableadmin.com.

## 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