Registration Form

Teamsters Local Union 230 Members' Benefit Fund

This Registration Form is a legal document and replaces all previous Registration Forms.

New Enrolment / Type of Change

☐ New member ☐ Name change ☐ Change of address ☐ Change of dependent
☐ Banking information change ☐ Beneficiary change ☐ Other: _____

Effective Date
Month Day Year

Member Information

Home Local	Social Insurance Number (SIN)	Language Preference	Gender
		☐ English ☐ French	☐ Female ☐ Male ☐ Other

Last Name	First Name	Date of Birth
		Month Day Year

Mailing Address	City	Province	Postal Code

Phone Number	Cell Number	Email Address

Marital Status	Effective date of marital status	If common-law, confirm date of co-habitation
☐ Single ☐ Widowed ☐ Common-law ☐ Divorced ☐ Separated ☐ Married	Month Day Year	Month Day Year

Spouse Information *(If single, continue to Dependent Information section)*

Definition as it pertains to your Group Benefit Plan

Spouse means either the person who is lawfully married to the member or a common-law partner, including a same-sex partner, with whom the member has co-habited for a period of at least 12 months and who is publicly presented as the member's spouse/partner.

Declaration of Common-Law Spouse

Complete if your common-law spouse has not been registered with the fund office for more than one year.

I _____ do solemnly declare _____ to be my common-law spouse and our relationship as such commenced on the _____ day of, 20____ and has continued uninterrupted to the present time. I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.

Member Signature_____

Last Name	First Name	Date of Birth	Gender
		Month Day Year	☐ Female ☐ Male ☐ Other

Mailing Address ☐ Same as above	City	Province	Postal Code

Coordination of Benefits

Where applicable, benefit payments will be coordinated between this plan and your spouse's plan in accordance with Canadian Life and Health Insurance Association (CLHIA) regulations. Your spouse's claims must first be submitted to their plan and any unpaid portion can be submitted to this plan.

Does your spouse/common-law partner have coverage under their own group insurance plan? ☐ Yes ☐ No If Yes, complete the below.

Benefit Type	Coverage Type	Insurer Name	Start Date	End Date
Dental	☐ Single ☐ Family ☐ None		Month Day Year	Month Day Year
Vision	☐ Single ☐ Family ☐ None		Month Day Year	Month Day Year
Prescription Drugs	☐ Single ☐ Family ☐ None		Month Day Year	Month Day Year
Extended Health	☐ Single ☐ Family ☐ None		Month Day Year	Month Day Year

Plan Administrator
Ellement Consulting Group
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Dependent Children Information

Dependent children are covered for health and dental benefits until their 21st birthday. You can continue to maintain coverage for your over-age dependent until their 25th birthday provided they are a full-time student attending an accredited institute of learning and dependent on you for support, or have a permanent disability. To apply for over-age dependent status, you will be required to adhere to the process established by your group benefit plan.

Relationship Codes: S = Son, **D =** Daughter, **SC =** Stepchild, **O =** Other

Note: If the relationship is "Other", Proof of Guardianship documents are required.

Primary Residence Codes: Both = Both Parents, **F =** Father, **M =** Mother, **S =** 50/50 Custody, **O =** Other

	Last Name	First Name	Date of Birth	Gender	Full-time Student	Disabled Child	Relationship Code	Primary Residence Code
1			Month Day Year	☐ Female ☐ Male ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No		
2			Month Day Year	☐ Female ☐ Male ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No		
3			Month Day Year	☐ Female ☐ Male ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No		
4			Month Day Year	☐ Female ☐ Male ☐ Other	☐ Yes ☐ No	☐ Yes ☐ No		

	Is your dependent covered under any other group insurance plan? ☐ Yes ☐ No If yes, complete the below.		
1	**Benefit** ☐ Dental ☐ Extended Health ☐ Vision ☐ Prescription Drugs	**Effective Date** Month Day Year	**End Date (if terminated)** Month Day Year
2	**Benefit Type** ☐ Dental ☐ Extended Health ☐ Vision ☐ Prescription Drugs	**Effective Date** Month Day Year	**End Date (if terminated)** Month Day Year
3	**Benefit Type** ☐ Dental ☐ Extended Health ☐ Vision ☐ Prescription Drugs	**Effective Date** Month Day Year	**End Date (if terminated)** Month Day Year
4	**Benefit Type** ☐ Dental ☐ Extended Health ☐ Vision ☐ Prescription Drugs	**Effective Date** Month Day Year	**End Date (if terminated)** Month Day Year

Beneficiary Designation *(Ensure to complete both the Health Benefits & Pension sections)*

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The following beneficiary appointment(s) will apply to all eligible benefits under your group insurance plan. If you wish to make the beneficiary nomination irrevocable, please contact the plan administrator. If you do not nominate a beneficiary, the proceeds will be paid to your Estate. If it is your intent to assign your estate as the beneficiary, please print ESTATE. You are responsible for ensuring the validity of your designation.

Quebec Residents: Unless otherwise specified, the designation of a legal spouse or spouse joined in a civil union as beneficiary is IRREVOCABLE. Unless otherwise specified, the designation of any other person as beneficiary is REVOCABLE.

- Revocable means the designation can be changed or revoked by the member at any time without the beneficiary's consent.
- Irrevocable means the designation **cannot** be changed or revoked by the member without the written beneficiary's consent and unless certain requirements are met. The irrevocable of a minor **cannot** be changed until they reach the age of majority defined by their province of residence.

I hereby make the below beneficiary designation: ☐ Revocable, I may change this beneficiary designation at any time

All other provinces: The designation of beneficiary is revocable unless otherwise specified.

Beneficiary for Health Benefits

Last Name	First Name	Date of Birth	Relationship	Percentage *(must add up to 100%)*
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		

The Administrator will retain the original beneficiary nomination and all future beneficiary designations. The legal beneficiary is the named beneficiary on file with the Administrator. You may wish to consult a legal advisor before designating a beneficiary. If the beneficiary is under the age of majority, please complete the Declaration of Appointing Trustee below.

Trustee Appointment *(not applicable in Quebec)*

This section is to be completed if any appointed beneficiary(ies) is/are under the age of the majority or lack legal capacity. This is not applicable to Quebec residents where appointments are governed by the Quebec Civil Code.

I do hereby appoint _____ as Trustee to receive and hold in Trust, on behalf of any beneficiary, any amount due to any beneficiary under the age of the majority or who lacks legal capacity (at the time payment is payable). I declare that the receipt of payment by such Trustee shall be sufficient discharge to the Insurer, the Trust Fund, or Ellement Consulting Group from any further liability.

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Banking Information

Name of Financial Institution

Transit #

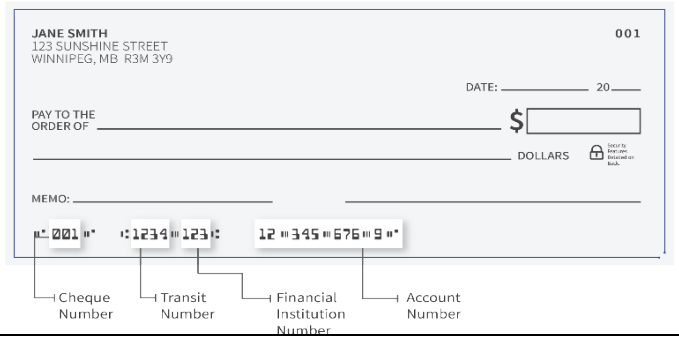
5 digits

Institution #

3 digits

Account #

maximum 12 digits



By providing your banking information, your claim payments will be deposited directly into your bank account.

☐ **Mandatory: I have enclosed a VOID cheque or an authorization form from my financial institution.**
Important: Lines of credit cheques or US accounts are not accepted.

Authorization and Consent

I hereby apply for the benefits and pension for which I am or may become eligible under these group plans. To participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependent children may be eligible, my social insurance number is required for income tax purposes. I consent to the use of my social insurance number for those purposes and consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and/or administrating the plans.

I also consent to the collection, use, storage, disclosure, and destruction of my personal information or my spouse and dependents personal information, to relevant persons and/or organizations such as, but not limited to: Institutions, Government Agencies, Investigating Agencies, the Union, Trustees, Companies affiliated with Ellement Consulting Group, Insurers, Re-Insurers, Auditors, and Regulators to manage the plans and entitlement to the benefits of the plans when that personal information is needed for the purpose of adjudicating claims and/or administrating the plans.

I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally to become eligible for and remain a member of the plans.

I understand that Ellement Consulting Group can, without prior notice, terminate the direct deposit of benefits and issue cheques to me. Also, I grant Ellement Consulting Group the right to correct any credit entries resulting from an erroneous overpayment by debiting my account to the extent of such overpayment. This authorization is to remain in full force and effect until Ellement Consulting Group has received written authorization of its termination or change in such time and manner as to give Ellement Consulting Group a reasonable opportunity to act on it.

I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

Privacy Statement: Ellement Consulting Group will collect, use, maintain and disclose communicate only the personal information considered necessary for the administration of the plan. Personal information will be protected pursuant to the relevant legislation. The plan may use and exchange information with the relevant persons and/or organizations such as, but not limited to: Institutions, Government Agencies, Investigating Agencies, the Union, Trustees, Companies affiliated with Ellement Consulting Group, Insurers, Re-Insurers, Auditors, and Regulators to manage the plan and entitlement to the benefits of the plan. Questions related to the privacy policy should be directed to our Privacy Officer by mail, or by email at privacy@ellement.ca .

Member Signature ***(must be in ink)***

Month Day Year

Date Signed

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