

**TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN**

c/o Convyta Partners
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Check as Applicable:

- Original Form
- Replacement Form
- Change to Spouse or Dependent Information

SUBSIDIZED RETIREMENT PLAN (SRP) ENROLMENT FORM

Please PRINT clearly in ink and ensure that you and a witness have signed and dated it. Once completed, file this form with the Plan Administrator at the above address. This is a two-sided form – please see reverse.

| 1. MEMBER INFORMATION | | | | | |
|---|--|--|--|---|--------------------------|
| LAST NAME: | | FIRST NAME: | | INITIAL(S): | SOCIAL INSURANCE NUMBER: |
| ADDRESS (street number and name): | | | APARTMENT OR SUITE: | DATE OF BIRTH (mm-dd-yyyy): | |
| CITY: | | PROVINCE: | POSTAL CODE: | PHARMACARE REGISTRATION NO. (where applicable): | |
| TELEPHONE NO: | EMAIL ADDRESS: | | GENDER: <input type="checkbox"/> M <input type="checkbox"/> F | | |
| 2. MARITAL STATUS DECLARATION | | | | | |
| For purposes of the Teamsters Local Union No. 155 Subsidized Retirement Plan, “Spouse” means: | | | | | |
| <ul style="list-style-type: none"> • a legally married spouse; or • a common-law spouse (a person who has lived with you for at least 12 months and is represented as your spouse). | | | | | |
| I hereby certify that, as of the date of this declaration, I have a Spouse as follows and that the information provided below is complete and accurate. I agree to notify the Plan Administrator of any changes to my marital status. | | | | | |
| LAST NAME: | | FIRST NAME: | | INITIAL(S): | |
| DATE OF BIRTH (mm-dd-yyyy): | GENDER: <input type="checkbox"/> M <input type="checkbox"/> F | DATE OF MARRIAGE, OR DATE OF COMMENCEMENT OF COMMON-LAW: | | | |
| 3. DEPENDENT INFORMATION (other than Spouse) | | | | | |
| List all eligible dependents, other than your Spouse. If adding children over 19, indicate the school they are attending full-time. | | | | | |
| LAST NAME | MIDDLE INITIAL | FIRST NAME | DATE OF BIRTH (mm-dd-yyyy) | GENDER | RELATIONSHIP TO YOU |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| 3. CO-ORDINATION OF BENEFITS | | | | | |
| Are you covered by another benefit plan (e.g., your Spouse’s plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If yes, indicate the type of benefits covered: | | | Policy No(s): | Name if Insurance Carrier: | |
| 4. SIGNATURE OF MEMBER | | | | | |
| I, the undersigned, hereby: | | | | | |
| (a) apply to be enrolled as a Member of the Teamsters Local Union No. 155 Subsidized Retirement Plan. | | | | | |
| (b) understand that completion of this form does not in itself, entitle a Member to benefits – qualification for benefits is in accordance with the rules of the Plan. | | | | | |
| (c) agree to be bound by the rules of the Plan, as amended from time to time; | | | | | |
| (d) certify that the information provided on this form is complete and accurate and may be relied upon by the Plan Administrator; | | | | | |
| (e) agree to promptly notify the Plan Administrator of any changes to my marital status or dependent information; | | | | | |
| (f) understand that failure to provide accurate or updated information may affect my coverage or benefits under the Plan; | | | | | |
| (g) consent to the collection, use, and disclosure of my personal information, including my Social Insurance Number, as reasonably required to administer the Plan and for tax reporting purposes; | | | | | |
| (h) consent to receiving Plan-related documents and information electronically. | | | | | |
| Signature of Member | | | | Date (mm-dd-yyyy) | |
| X | | | | | |
| Signature of Witness (cannot be Spouse or Dependent) | | | | Name of Witness | |
| X | | | | | |

PRIVACY STATEMENT: The Trustees of the Health Benefits Plan will collect, use and disclose personal information (including Social Insurance Number) if reasonably necessary to effectively administer the Health Benefits Plan. Personal information will be protected pursuant to the relevant privacy legislation. The Trustees may use and exchange information with relevant persons or organizations (union, health professionals, financial institutions, insurers, re-insurers, regulators, investigative agencies) in order to manage the Plan and your entitlement under the Plan. Questions related to the Privacy Policy of the Funds and Plans should be directed to the Administrator.