GROUP BENEFITS CHANGE FORM

Once completed, submit to:
Labourers Local 493
Welfare Trust Fund
584 Clinton Ave.
Sudbury, ON P3B 2T2

1 WHAT IS THE EFFECTIVE DATE OF THE CHANGE (MM/DD/YYYY):_____

COMPANY NAME :LOCAL 493 WELFARE TRUST FUND CERTIFICATE NUMBER:_____

- ☐ MEMBER TERMINATION
- ☐ MEMBER DIVISION AND/ OR CLASS TRANSFER :: PROVIDE NEW DIVISION_____CLASS_____
- ☐ MEMBER EARNINGS CHANGE :: PROVIDE NEW EARNINGS_____ PER ☐ YEAR ☐ MONTH ☐ WEEK ☐ HOUR
- ☐ ADD OR REMOVE SPOUSE OR DEPENDENT :: MEMBER TO COMPLETE SECTIONS 2, 5 & 6
- ☐ LOSS OR ADDITION OF SPOUSAL COVERAGE :: MEMBER TO COMPLETE SECTIONS 2, 5 & 6 FOR LOSS; SECTIONS 2, 3, 5 & 6 FOR ADDITION
- ☐ BENEFICIARY CHANGE :: MEMBER TO COMPLETE SECTIONS 2, 4 & 6
- ☐ CHANGE OF NAME AND / OR ADDRESS :: MEMBER TO COMPLETE SECTIONS 2 & 6

2 PLAN MEMBER INFORMATION: ALL APPLICABLE SECTIONS TO BE COMPLETED IN INK. PLEASE PRINT CLEARLY.

PLAN MEMBER LAST NAME | FIRST | INITIAL

TELEPHONE | EMAIL

MAILING ADDRESS

CITY | PROVINCE | POSTAL CODE

DO YOU HAVE A SPOUSE ☐ YES ☐ NO COMMON-LAW SPOUSE ☐ YES ☐ NO IF YES, START DATE OF CO-HABITATION

DO YOU HAVE DEPENDENT CHILDREN, INCLUDING FULL-TIME STUDENTS OR DISABLED ADULTS ☐ YES ☐ NO

3 REQUESTED COVERAGE. HEALTH AND/OR DENTAL COVERAGE

I WISH TO APPLY FOR:

HEALTHCARE FOR ☐ MYSELF AND MY DEPENDENTS ☐ MY DEPENDENTS ONLY DENTAL CARE ☐ MYSELF AND MY DEPENDENTS ☐ MY DEPENDENTS ONLY

SPOUSAL INSURANCE NAME: CERTIFICATE NUMBER: PLAN MEMBER ID:

MEMBER OTHER INSURANCE NAME: CERTIFICATE NUMBER: PLAN MEMBER ID:

4 BENEFICIARY DESIGNATION: THIS SECTION MUST BE COMPLETED TO DESIGNATE A BENEFICIARY FOR YOUR LIFE AND/OR AD&D BENEFITS, IF APPLICABLE.

THE ORIGINAL OF THIS FORM WILL BE REQUIRED FOR A CLAIM. CROSSED OUT BENEFICIARY DESIGNATIONS MUST BE INITIALED. IF NO BENEFICIARY IS DESIGNATED, BENEFITS ARE PAYABLE TO THE MEMBER'S ESTATE. IF YOU ARE DESIGNATING AN EXECUTOR (LIQUIDATOR IN QC), WE RECOMMEND YOU CONSULT WITH A LEGAL ADVISOR, AND WITH ANY PROPOSED AN EXECUTOR (LIQUIDATOR IN QC).

BENEFICIARY'S LAST NAME(S) | FIRST | INITIAL | RELATIONSHIP TO MEMBER | PERCENTAGE %

BENEFICIARY'S LAST NAME(S) | FIRST | INITIAL | RELATIONSHIP TO MEMBER | PERCENTAGE %

BENEFICIARY'S LAST NAME(S) | FIRST | INITIAL | RELATIONSHIP TO MEMBER | PERCENTAGE %

BENEFICIARY'S LAST NAME(S) | FIRST | INITIAL | RELATIONSHIP TO MEMBER | PERCENTAGE %

TO BE DIVIDED AS FOLLOWS ☐ AS PER THE PERCENTAGES INDICATED ABOVE, OR ☐ IN EQUAL SHARES TO THE SURVIVING DESIGNATED BENEFICIARIES)

YOU MUST MAKE YOUR BENEFICIARY DESIGNATION REVOCABLE OR IRREVOCABLE BY CHECKING ONE OF THE BOXES BELOW. YOU MAY CHANGE THE REVOCABLE BENEFICIARY AT ANY TIME. YOU MAY NOT CHANGE AN IRREVOCABLE BENEFICIARY DESIGNATION OR MAKE CERTAIN CHANGES TO YOUR PLAN WITHOUT THE WRITTEN CONSENT OF THE IRREVOCABLE BENEFICIARY. NOTE: WHERE QUEBEC LAW APPLIES AND YOU HAVE DESIGNATED YOUR MARRIED SPOUSE OR COMMON LAW SPOUSE AS BENEFICIARY, THE DESIGNATION WILL BE IRREVOCABLE UNLESS YOU CHECK THE BOX "REVOCABLE" BELOW.

I HEREBY MAKE THE ABOVE BENEFICIARY DESIGNATION: ☐ REVOCABLE ☐ IRREVOCABLE

GROUP BENEFITS CHANGE FORM

5 SPOUSE AND DEPENDENT INFORMATION: COMPLETE THIS SECTION IF YOU HAVE NOT REFUSED COVERAGE FOR YOUR SPOUSE AND DEPENDENTS IN SECTION 3.

SPOUSE/COMMON LAW SPOUSE

◉ Add ○ Change ○ Delete

LAST NAME _____ FIRST NAME _____ INITIAL _____

DATE OF BIRTH (MM/DD/YYYY) _____ GENDER ☐ MALE ☐ FEMALE

WHAT COVERAGE DOES YOUR SPOUSE/COMMON LAW SPOUSE HAVE THROUGH THEIR EMPLOYER:

HEALTHCARE	DENTAL CARE	VISION CARE
☐ SINGLE	☐ SINGLE	☐ SINGLE
☐ FAMILY	☐ FAMILY	☐ FAMILY
☐ WAIVED	☐ WAIVED	☐ WAIVED
☐ NONE	☐ NONE	☐ NONE

DEPENDENT CHILDREN

Add	Change	Delete	LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	GENDER	F/T STUDENT	DISABLED
◉	○	○					☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO
◉	○	○					☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO
◉	○	○					☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO
◉	○	○					☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO

6 AUTHORIZATIONS AND DECLARATIONS: THIS SECTION MUST BE SIGNED AND DATED IN INK BY PLAN MEMBER.

I HEREBY APPLY FOR COVERAGE UNDER THE GROUP BENEFITS PLAN PROVIDED BY MY EMPLOYER/PLAN SPONSOR. I AUTHORIZE MY PLAN SPONSOR TO DEDUCT FROM MY PAY AND REMIT TO THE INSURANCE PROVIDER PLAN MEMBER CONTRIBUTIONS REQUIRED UNDER THE PLAN, IF APPLICABLE.

I AUTHORIZE THE INSURANCE PROVIDER TO USE MY SOCIAL INSURANCE NUMBER FOR TAX REPORTING PURPOSES AND AS AN IDENTIFICATION NUMBER WHERE IT IS REQUIRED IN THE ADMINISTATION OF MY PLAN.

I AUTHORIZE THE INSURANCE PROVIDER, ANY HEALTHCARE PROVIDER, INDEPENDENT BROKER, SALES ADVISOR, PLAN ADMINISTRATOR, OTHER INSURANCE OR REINSURANCE COMPANIES, ADMINISTRATORS OF GOVERNMENT BENEFITS OR OTHER BENEFIT PROGRAMS, OTHER ORGANIZATIONS OR SERVICE PROVIDERS TO EXCHANGE THE PERSONAL INFORMATION WILLINGLY PROVIDED BY ME, WHEN RELEVANT AND NECESSARY FOR THE PURPOSES OF UNDERWRITING, SERVICING, CLAIMS PROCESSING, ADJUDICATION AND DETERMINING MY ELIGIBILITY FOR COVERAGE AND TO ADMINISTER THE PLAN.

I AUTHORIZE THE PROVIDER, ITS AGENTS AND SERVICE PROVIDERS, AND ITS REINSURERS TO COLLECT, USE AND DISCLOSE INFORMATION NEEDED FOR UNDERWRITING, ADMINISTRATION AND CLAIMS UNDER THIS PLAN TO ANY PERSON OR ORGANIZATION WHO HAS RELEVANT INFORMATION PERTAINING TO THE ABOVE INFORMATION, INCLUDING HEALTH PROFESSIONALS, INSTITUTIONS, INVESTIGATIVE AGENCIES, AND INSURERS.

IN APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION ALSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES.

I AGREE THAT A PHOTOCOPY OR ELECTRONIC COPY OF THE AUTHORIZATION AND DECLARATIONS SECTION IS AS VALID AS THE ORIGINAL.

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PLAN MEMBER SIGNATURE DATE

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584 Clinton Ave.
Sudbury, ON P3B 2T2