

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 : _____ 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 %
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

*IF ANY BENEFICIARY ARE MINORS YOU CAN NAME A TRUSTEE _____
 NAME: _____ RELATIONSHIP TO MEMBER _____

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			
<p>LAST NAME _____ FIRST NAME _____ INITIAL _____</p> <p>DATE OF BIRTH (MM/DD/YYYY) _____ GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p> <p>WHAT COVERAGE DOES YOUR SPOUSE/COMMON LAW SPOUSE HAVE THROUGH THEIR EMPLOYER:</p> <table style="width: 100%;"> <tr> <td style="width: 33%;"> HEALTHCARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE </td> <td style="width: 33%;"> DENTAL CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE </td> <td style="width: 33%;"> VISION CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE </td> </tr> </table>				HEALTHCARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE	DENTAL CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE	VISION CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE
HEALTHCARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE	DENTAL CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE	VISION CARE <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> WAIVED <input type="checkbox"/> NONE				

DEPENDENT CHILDREN

Add	Change	Delete								
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME _____</td> <td style="width: 25%;">FIRST NAME _____</td> <td style="width: 10%;">INITIAL _____</td> <td style="width: 20%;">DATE OF BIRTH (MM/DD/YYYY) _____</td> <td style="width: 10%;">GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</td> <td style="width: 10%;">F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 10%;">DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table>	LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO				
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME _____</td> <td style="width: 25%;">FIRST NAME _____</td> <td style="width: 10%;">INITIAL _____</td> <td style="width: 20%;">DATE OF BIRTH (MM/DD/YYYY) _____</td> <td style="width: 10%;">GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</td> <td style="width: 10%;">F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 10%;">DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table>	LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO				
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME _____</td> <td style="width: 25%;">FIRST NAME _____</td> <td style="width: 10%;">INITIAL _____</td> <td style="width: 20%;">DATE OF BIRTH (MM/DD/YYYY) _____</td> <td style="width: 10%;">GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</td> <td style="width: 10%;">F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 10%;">DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table>	LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO				
			<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME _____</td> <td style="width: 25%;">FIRST NAME _____</td> <td style="width: 10%;">INITIAL _____</td> <td style="width: 20%;">DATE OF BIRTH (MM/DD/YYYY) _____</td> <td style="width: 10%;">GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</td> <td style="width: 10%;">F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 10%;">DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table>	LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME _____	FIRST NAME _____	INITIAL _____	DATE OF BIRTH (MM/DD/YYYY) _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	F/T STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DISABLED <input type="checkbox"/> YES <input type="checkbox"/> 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 ADMINISTRATION 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

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