GROUP COVERAGE ENROLMENT FORM

Labourers Local 493
Welfare Trust Fund
584 Clinton Ave.
Sudbury ON P3B 2T2
ph: 705-805-5601 fax:705-674-6728
email:benefits493@liunalocal493.ca

****All sections must be completed for processing**

Plan Administrator

This section is to be completed by the Plan Administrator

The waiting period can only be waived with written consent from the insurer.

○New Enrolment ○ Reinstatement of Coverage ○ Change in Coverage (YY/MM/DD):_____

Plan Sponsor: **Labourers Local 493 Welfare Trust Fund** Division number: _____

Benefit class: _____Cert #: _____ Province of employment: _____

Date of full-time employment/reinstatement: Year: _____ Month: _____ Day: _____

Does the waiting period apply: ○ No ○ Yes

Occupation: _____

Earnings: _____ per ○ year ○ month ○ week ○ hourly

Schedule hours/week: _____

Plan Member Information

This section is to be completed by the Plan Member

Please print clearly, in INK

Member: _____
last name first name middle initial

○Male ○ Female Date of Birth: Year _____ Month _____ Day _____

Member Street address:_____

City:_____ Province: _____ Postal Code: _____

Email Address:_____

Do you have a Spouse? ○No ○Yes

Common law spouse? ○No ○Yes Date of co-habitation _____

Do you have other dependents, which includes children/students/disabled persons? ○ Yes ○ No

Plan Member Coverage through another Plan Sponsor

This section is to be completed by the plan member if applicable.

Do you currently have benefits coverage through another Employer/Union that you were/are a member of or were/are employed by: ○Yes ○No

Name of other carrier: _____ Plan Number: _____ Certificate Number: _____

What group benefits are you currently covered for through another Employer / Union benefits plan:

DENTAL ○ Single ○ Family ○ None

HEALTH ○ Single ○ Family ○ None

Requested Coverage

This section is to be completed by the Plan Member.

I wish to apply for:

Healthcare for ○ myself ○ myself and my dependents

Dentalcare for ○ myself ○ myself and my dependents

LiUNA493

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This section is to be completed by the Plan Member.

Complete this section only if you have requested dependent coverage above. Please print clearly, in INK.

○**Spouse**

○**Common Law - Date of co-habitation** _____

_____
last name first name middle initial

Date of birth
Year _____ Month _____ Day _____

Gender
○ Male ○ Female

Spousal insurer's name: _____
Plan number: _____ Certificate Number: _____

What group benefits coverage does your spouse/common law spouse have through their employer?

HEALTH ○ Single ○ Family ○ Children only ○None

DENTAL ○ Single ○ Family ○ Children only ○None

Complete this section only if you have requested dependent coverage above. If there are more than 4 dependents, please attach a separate list. Please print clearly, in INK.

Child/ren Information	**Date of birth**	**Gender**		**Full time student***		**Disabled dependent****	
	Year/Month/Day	Male	Female	Yes	No	Yes	No
_____ last name first name middle initial	_____/_____/_____	○	○	○	○	○	○
_____ last name first name middle initial	_____/_____/_____	○	○	○	○	○	○
_____ last name first name middle initial	_____/_____/_____	○	○	○	○	○	○
_____ last name first name middle initial	_____/_____/_____	○	○	○	○	○	○

Direct Deposit

If you wish to have your Extended Health Care and/or Dental Care benefit payments deposited directly into your bank account, you must complete the direct deposit form and attach a void cheque, a bank verification statement or a printed online direct deposit form. These forms must contain your name, the Bank Institution Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

*A student is a child age 22 or over but, under 25, who is a full-time student attending an educational institute recognized by Canada Revenue Agency, as long as the child is not married or in any formal union and that is dependent on you for financial support.
**To enroll an over-age dependent child, complete a Disabled Child Coverage Form and send to us within 6 months of the date the dependent reaches the age limit.

Beneficiary Designation

This section is to be completed by the Plan Member.

The original copy of this form will be required for a life claim.

If a beneficiary is not assigned "ESTATE" will be assumed

Beneficiary's Name(s)			Percent allocated	Relationship to Employee
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

You must make your beneficiary designation revocable or irrevocable by checking one of the circles below. You may change a revocable beneficiary designation 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 Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable" below.

I hereby make the above beneficiary designation: ○ **Revocable** ○ **Irrevocable**

*If you designate a minor child as the beneficiary of your insurance proceeds, these proceeds will be paid into court unless a trustee is appointed to receive such benefits on behalf of such child. Proceeds payable to a minor in Quebec will be paid out in accordance with the provisions of the Quebec Civil Code. You may wish to consult a lawyer before appointing a minor beneficiary.

Contingent Beneficiary Designation

This section is to be completed by the Plan Member.

Contingent Beneficiary's Name(s)			Percent allocated	Relationship to Employee
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

Nomination of Trustee

This section to be completed by the Plan Member for any beneficiaries that are under the age of majority.

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

Please print clearly, in INK.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

I designate the person(s) named above under Beneficiary Designation as my beneficiary(ies). The personal information willingly provided by me to LIUNA 493 Welfare Trust Fund, the independent broker / sales advisor and / or The Insurer, Administrator, collected on this Application and held in their files, will be used by The Insurer for the purposes of underwriting, servicing, administration, claims processing and adjudication related to this Application, the Group Insurance Policy and all benefits there under, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by The Insurer, participating re-insurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize.

If 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 understand that all claims made under the Group Insurance Policy are submitted through me as insured Plan Member. I therefore authorize The Insurer to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purposes of confirming eligibility and assessing and managing the claim.

X _____ _____

Plan Member Signature — Date

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

145 The West Mall, PO Box 110 U,
Toronto, ON M8Z 5M4

Direct Deposit Form

Direct deposit is a fast and convenient way to ensure you receive your claim payment as fast as possible.

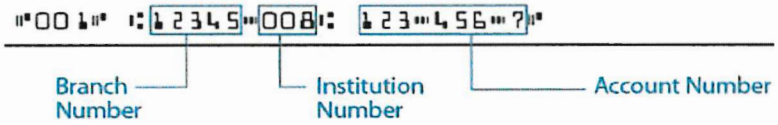
Policyholder Information (please print)

Policy #	Certificate #	Policy Name
Surname	Given Name(s)	Phone #
Address (#, Street Name)		Apartment #
City	Province	Postal Code
E-mail Address (mandatory)		

Bank Information

Please complete the following information and **attach a blank cheque with "VOID" written across the front or a bank issued Pre-Authorized Payment/Deposit form.** ***Any forms without the required documents will not be updated.***

Is this request for: New information ☐ Change information ☐	Financial Institution Name	
Transit #	Institution #	Account #



Authorization

The information that I have provided above is accurate. I will notify NexgenRx of any changes to this data. Please allow NexgenRx to credit my bank account (as per the details provided above) with all my benefit payments.NexgenRx or I can cancel this agreement at any time with written or verbal notice.

Policyholder's Signature	Date
Bank account holder's Signature (if not the same as the policyholder)	Date

At NexgenRx, we know the importance of maintaining your privacy and the confidentiality of personal information. All personal information concerning yourself and your dependants (if any) will be collected, used and disclosed by NexgenRx only for the purposes of adjudicating claims, administering your benefit plan or for certain ancillary purposes, all as set out in the NexgenRx Privacy Policy published on our website at www.nexgenrx.com. You may obtain a printed copy of such Privacy Policy by writing to us at 145 The West Mall, PO Box 110 U, Toronto, Ontario M8Z 5M4, to the attention of our Chief Privacy Officer.