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Before signing this form, you should understand the meanings of the "Explanation" and the "Authorization". If clarification is needed, please contact the Administrator of the Plan.

Explanation: Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your Dependants and Beneficiary(ies). It comes from this form, the reports your employers and the sponsoring Union submit to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Administrator of the Plan, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess plan performances; accommodate audits of the Plan; and, if applicable, transfer data to new replacement Plans. Personal information will be used for no other purpose without your express written permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the Administrator of the Plan.

Member Information

Social Insurance Number - -	Certificate	Member's Last Name	Member's First Name
Apt# and Street Address	Town or City	Province	Postal Code
Home Phone Number ( ) -	Cell Phone Number ( ) -	E-mail Address	

Member's Date of Birth Year Month Day / /	Gender ☐ Male ☐ Female	Marital Status ☐ Married ☐ Common-law ☐ Divorced ☐ Single ☐ Separated ☐ Widowed	Date of Marriage / Cohabitation Year Month Day / /	Date of Separation / Divorce Year Month Day / /

Health & Welfare Plan Information

Designation of Dependants under the Health & Welfare Plan: Please list all of your Health & Welfare Dependants (including your spouse / common-law spouse, unmarried children under 21 years of age, unmarried children under 25 if in full time attendance at an accredited school or university and supported by the Member, and, at any age, if physically or mentally challenged and living with the Member) below. Only those Dependants, listed below, or on a separate listing that you provide, will be considered for coverage. Please note: Documentation may be required to verify eligibility of Dependants age 21 or older.

Spouse / Common-law's Last Name	Spouse / Common-law's First Name	Relationship to Member	Date of Birth Year Month Day / /
Dependant's Last Name	Dependant's First Name	Relationship to Member	Date of Birth Year Month Day / /
Dependant's Last Name	Dependant's First Name	Relationship to Member	Date of Birth Year Month Day / /
Dependant's Last Name	Dependant's First Name	Relationship to Member	Date of Birth Year Month Day / /

Life Insurance Beneficiary(ies): I hereby appoint the following Beneficiary(ies) to receive any proceeds that may be payable under the Health & Welfare Plan by reason of my death. I reserve the right to change my Beneficiary(ies) from time to time, subject to complying with the applicable rules governing the designation of Beneficiaries. If my Beneficiary(ies) predeceases me, and no other have been appointed, the proceeds, if any shall be payable to my estate.

Life Insurance Beneficiary's(ies') Last Name	First Name	Date of Birth Year Month Day / /	Telephone Number ( ) -
Life Insurance Beneficiary's(ies') Address			

Appointment of Trustee for Underage Beneficiary(ies): I HEREBY appoint_____, if living, as Trustee to receive and disburse any monies payable to any minor child(ren) named as beneficiary(ies) under my Life Insurance benefit during the minority, and any payment so made to the said Trustee shall discharge the Health & Welfare Plan to the extent of such payment.

Authorization: I hereby authorize the Trustees and the Administrator of the Plan to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this form, and coordinate my records with those of UFCW Local 247. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this form, is true, correct, and complete, to the best of my knowledge and belief. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

_____ _____

Signature of Member Date Signed