Canadian Elevator Industry Welfare Plan

MEMBER INFORMATION CARD

PERSONAL INFORMATION

Last Name		First Name		Middle Init.
Date of Birth Day Month Year	Gender Male ☐ Female ☐	Social Insurance Number (SIN) *	Certificate Number	

** I hereby authorize the use of this number by the Plan Administrator for Tax reporting and the administration of my benefits, as required.*

I hereby authorize the Plan Administrator to use the information provided by me on this card to administer my benefits. I further consent to the release of this information to my insurer, if applicable and required by my insurer, and to my local union office for authorization, if required under this Plan.

Member's Signature ______________________ **Date** ______________________

HOME / MAILING ADDRESS

Apt	Address		City, Town or Village
Province	Postal Code	Phone ( )	Email

UNION INFORMATION

Date of Employment	Date of Plan Participation	Most Recent Date Joined Union	**Local #:**______________________
Day Month Year	Day Month Year	Day Month Year	______________________ **Signature of Local Union Official and Union Seal**

This Section Is To Be Completed By The Local Union Office Only

MARITAL STATUS

☐ Never Married ☐ Divorced ☐ Separated ☐ Civil Union *(for Quebec only)* ☐ Widowed

<u>If you have a spouse, complete the spousal information section below</u>. **The definition of eligible spouse can be found in your Benefit Plan Booklet.**

☐ Common Law	☐ Married
Date of Co-habitation: Day Month Year	**Date of Marriage: Day Month Year**
A notarized statement confirming the status of any common-law relationship must be provided to the Plan Administrator for your common-law spouse to be eligible for benefits.	

SPOUSAL INFORMATION

Last Name	First Name	Middle Init.	Date of Birth Day Month Year	Gender Male ☐ Female ☐

PLEASE COMPLETE BOTH SIDES OF THE FORM

PLEASE REMEMBER TO SIGN THE BACK OF THIS FORM

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CO-ORDINATION OF BENEFITS INFORMATION

Please provide information for ALL required fields

Are your spouse and children, if any, covered for health and dental with another insurance company through your spouse's employer?

NO ☐ YES ☐

	Single	OR	Family
Health	☐		☐
Drugs	☐		☐
Vision	☐		☐
Dental	☐		☐

Spouse's Insurance Company:

Policy #:

Spouse's Coverage Effective Date:

DEPENDENT CHILDREN

Last Name	First Name	Date of Birth Day Month Year	Gender	Student**	Disabled
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

**** Proof of full-time attendance at an accredited school, college or university must be provided annually if the child is over age. Please refer to your booklet.**

LIFE INSURANCE BENEFICIARY DESIGNATION

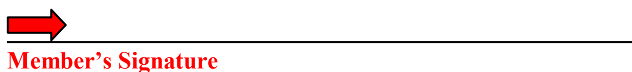
Last Name	**First Name**	**Date of Birth** Day Month Year	**Relationship**	**Percentage (100%)**

I hereby revoke all existing beneficiary(ies) designation(s) made by me for the Canadian Elevator Industry Welfare Plan and designate the person(s) named above as my beneficiary, if then living, to receive any benefits payable under the Canadian Elevator Industry Welfare Plan upon my death, reserving to myself the right to change or revoke such appointment, notwithstanding acceptance thereof and subject to any legal restrictions, by written notice to the Plan Administrator.

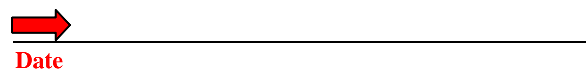
Where Quebec law applies, a spouse as beneficiary is irrevocable (and cannot be changed without the written consent of the irrevocable Beneficiary unless you make the designation revocable). I hereby make the designation:

☐ Revocable ☐ Irrevocable

I hereby certify that all the statements and information on this form are true.



Member's Signature



Date

Plan Administrator: Manion Wilkins & Associates Ltd, 500- 21 Four Seasons Place, Toronto, ON M9B 0A5