

MILLWORKERS HEALTH & WELFARE PLAN

D.A. TOWNLEY
& ASSOCIATES LTD.

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Burnaby BC V5C 6A8
Phone: (604) 299-7482 Fax: (604) 299-8136
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REVISED CARD - CHECK HERE

ENROLMENT CARD AND BENEFICIARY DESIGNATION

Please ensure this card is completed in full and that you have signed and dated it. **Note:** This card is for the Health & Welfare Plan only and will not update your beneficiary on your Pension Plan. If you are covered for the BC Medical Plan (MSP) through this Plan, you must complete a separate application or change form to update your MSP coverage. When card is fully completed - mail to the Administrator of the Plan.

MEMBER INFORMATION - Please print clearly

SURNAME		FIRST NAME		INIT.	PHARMACARE REGISTRATION NO
SOCIAL INSURANCE NUMBER		BIRTH DATE (Yr. Mo. Day)		PHONE # ()	MARITAL STATUS
ADDRESS (No. Street, City, Province, Postal Code)					
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Union Local		Initiation Date	

BENEFICIARY DESIGNATION

I hereby appoint _____ (if living, otherwise my estate) as revocable beneficiary of any insurance payable in the event of my death, under the terms of the contract or contracts held by the Trustees.

Beneficiary Relationship: _____

CO-ORDINATION OF BENEFITS

Are you covered by another benefit plan (i.e., your Spouse's plan)? NO YES

If YES, benefits covered: _____, Spouse's SIN: _____

Policy No(s): _____ Insurance Carrier: _____

To Protect Your Privacy: In order to verify your identity when you call the Administrator, please provide a personal fact or question along with the answer that only you would be able to answer. (i.e., your mother's maiden name, place of birth, etc.).

Question: _____ Answer: _____

I authorize the use of my Social Insurance Number for identification purposes and I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits; to determine the cost and financially manage these benefits as well as to meet regulatory or contractual requirements and any Trust obligations relating to such benefits and related services provided.

DATE: _____ **MEMBER'S SIGNATURE:** _____

DEPENDENT INFORMATION - List all eligible dependents

FIRST NAME	SURNAME (if different from Member's)	RELATIONSHIP TO MEMBER	BIRTH DATE (Yr. Mo. Day)	STUDENT Y/N
01 Spouse*				
02 (eldest first)				
03				
04				
05				

If adding a Spouse,
Date of marriage: _____

If adding a Common-Law Spouse,
Date of commencement of Common-Law relationship _____

If adding children over the age of 19,
indicate school they are attending full-time:

