

APPLICATION FOR ENROLMENT AND BENEFICIARY DESIGNATION

FOR OFFICE USE ONLY

Please complete in ink and print clearly. This is a two-sided form – please see reverse.

Please fill in all information and ensure you have signed and dated this form.

NOTE: This form is for the Health Plan ONLY and will not update your beneficiary on your Pension Plan. Page 1 of 2

MEMBER INFORMATION

NAME SURNAME		GIVEN NAME		INITIALS	SOCIAL INSURANCE NUMBER
ADDRESS (No. and Street)			CITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> PREFER NOT TO DISCLOSE <input type="checkbox"/> FEMALE <input type="checkbox"/> ANOTHER GENDER		DATE OF BIRTH (Y,M,D)	UNION AFFILIATION AND LOCAL NO.	
EMAIL ADDRESS <small>I hereby certify that I give permission to contact me by email for Benefit Plan purposes.</small>			EMPLOYER	DATE OF EMPLOYMENT (Year, Month, Day)	

MARITAL STATUS DECLARATION – Refer to other side for the definition of an eligible Spouse

I hereby certify that I have read the Definition of Spouse and that, as of the date of this declaration, I have a Spouse as follows:

SPOUSE’S NAME (Surname, Given Name & Initials)	GENDER (Male/Female)	DATE OF BIRTH (Year, Month, Day)	DATE OF MARRIAGE (Year, Month, Day)	COMMON-LAW* COHABITATION START DATE (Year, Month, Day)
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DEPENDENT INFORMATION (Other than Spouse) – List all eligible dependents, other than your Spouse, starting with the eldest: If adding children over 21, indicate the school they are attending Full-time.

NAME (Surname, Given Name & Initials)	RELATIONSHIP (Son/Daughter)	DATE OF BIRTH (Year, Month, Day)	FULL-TIME STUDENT (Yes/No) and name of School, if over 21

CO-ORDINATION OF BENEFITS

Are you covered by another benefit plan (ie your Spouse’s plan)? YES NO If YES, indicate the benefits covered: _____ Policy No(s) _____ Insurance Carrier _____

GROUP LIFE INSURANCE BENEFICIARY DESIGNATION

I designate the following individual(s)* as my revocable group life insurance beneficiary(ies), if living, otherwise my Estate* and revoke any prior designation I have made.

*Indicate Estate, if no named beneficiary.

NAME (Surname, First Name & Initials)	RELATIONSHIP	
		%
		%
If beneficiary is a minor, name adult trustee here >		

APPLICATION FOR ENROLMENT

I, the undersigned, hereby:

- apply to be enrolled as a Member of the N.D.T. Industry Health Benefit Plan,
- certify that the information provided on this form is correct,
- consent to the collection, use and disclosure of my personal information by the Board of Trustees of the Plan (or its authorized agent) for the purpose of administering the Plan and the benefits that may be conferred on Members of the Plan,
- agree to be bound by all the terms and conditions of the Plan,
- agree to promptly update the Plan Administrator on any changes to the status of a Spouse, dependent or beneficiary,**
- agree that I am liable for any benefit paid out incorrectly in the event that I have not updated the Plan Administrator on any change to the status of a Spouse, dependent or beneficiary,
- understand that completion of this form does not in itself entitle a Member to benefits – qualification for benefits is in accordance with the rules of the Plan,
- understand that the Plan Administrator shall have no responsibility to monitor the actions of a named Trustee on behalf of a minor beneficiary, and**
- certify that I have read the information provided on the reverse side of this form.**

*to add a common-law spouse to your benefit coverage, you must complete the common-law spouse declaration form – see Administrator.

SIGNATURE OF MEMBER

DATE

MEMBER INFORMATION				
NAME	SURNAME	GIVEN NAME	INITIALS	SOCIAL INSURANCE NUMBER
<p>DEFINITION OF SPOUSE – if you are indicating a spouse on the reverse side (page 1), under MARITAL STATUS DECLARATION, they must meet the following definition:</p> <p><i>The N.D.T. Industry Health Benefit Plan defines “Spouse” as: “The legal spouse of the employee, or, in the absence of a legal spouse, the common-law spouse of the Employee. The common-law spouse is a person with whom the Employee has been living and that living arrangement must be recognized as a conjugal relationship in the community in which the couple resides. Only one person may qualify as the spouse at any one time”. Common-law spouses must meet the Plan’s minimum co-habitation rule.</i></p>				
COMMON-LAW DEPENDENTS				
<p><i>Common-law spouses and their children may be eligible with a minimum cohabitation period as indicated in your group policy. NOTE: Only the children of your common-law spouse who are residing with you are considered eligible dependents. To add a common-law spouse to your benefit coverage, you must complete a common-law declaration form – see Administrator.</i></p>				
COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION				
<p><i>The collection, use and disclosure of an individual’s personal information by the Board of Trustees of the Plan (or the Trustees’ authorized agent including the Plan Administrator) during his/her participation in the Plan is for the purpose of administering the Plan and the benefits that are conferred on Members of the Plan. The collection, use and disclosure of personal information about individual Members of the Plan will be done in a manner that is reasonable. Furthermore, reasonable security arrangements will be taken to prevent any unauthorized access, collection, use, disclosure, copying, modification or disposal of personal information about individual Members of the Plan.</i></p>				
PRIVACY QUESTION				
<p>In order to verify your identity when you call the Plan Administrator, please provide a personal fact or question along with the answer that only you would be able to answer (mother’s maiden name, place of birth etc.):</p> <p>Question: _____</p> <p>Answer: _____</p>				

PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATOR:

D.A. Townley

4250 Canada Way
 Burnaby BC V5G 4W6
 Phone: (604) 299-7482 Fax: (604) 299-8136
 Toll-Free 1-800-663-1356
www.datownley.com www.ndtbenefits.org