

FOR OFFICE USE ONLY

**GROUP INSURANCE ENROLMENT FORM**

Please complete in ink and print clearly. Please fill in all information and ensure you have signed and dated this form. Page 1 of 2

<b>EMPLOYEE INFORMATION</b>			
EMPLOYEE'S SURNAME	FIRST	INITIAL	SOCIAL INSURANCE NUMBER
ADDRESS (No. and Street)	CITY	PROVINCE	POSTAL CODE
MARITAL STATUS	MALE/FEMALE	DATE OF BIRTH (Year, Month, Day)	PHARMACARE REGISTRATION NO. (where applicable)
<b>MARITAL STATUS DECLARATION - Refer to other side for the definition of an eligible Spouse</b>			
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 (if common-law see reverse) (Surname, First Name & Initials)	MALE/FEMALE	DATE OF BIRTH (Year, Month, Day)	DATE OF MARRIAGE (OR DATE OF COMMENCEMENT OF COMMON-LAW RELATIONSHIP)
<b>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.</b>			
NAME (Surname, First Name & Initials)	RELATIONSHIP (Son/Daughter)	DATE OF BIRTH (Year, Month, Day)	STUDENT (Yes/No) and name of school, if over 21
<b>CO-ORDINATION OF BENEFITS</b>			
Are you covered by another benefit plan (ie your Spouse's plan)? YES ___ NO ___ If YES, indicate the benefits covered:			
Benefits _____ Policy No(s) _____ Insurance Carrier _____			
<b>If you or your dependents do not require all benefits provided by your group insurance plan, you must complete the waiver on the reverse side of this form.</b>			
<b>GROUP LIFE INSURANCE BENEFICIARY DESIGNATION</b>			
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		%
			%
<b>TRUSTEE CLAUSE: If appointing a minor beneficiary, complete the following (Trustee must be of legal age):</b>			
I designate the following trustee to receive and disburse any monies payable under this group policy to my beneficiary(ies) during minority, and any payments made to this trustee will release the insurer of any further liability:			
Trustee's Full Name	Relationship to Employee		
<b>APPLICATION FOR ENROLMENT</b>			
I, the undersigned, hereby:			
<ul style="list-style-type: none"> <li>a) apply to be enrolled in the B.C. Marine Industry Employee Health Benefit Plan,</li> <li>b) certify that the information provided on this form is correct,</li> <li>c) consent to the collection, use and disclosure of my personal information by the 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,</li> <li>d) agree to be bound by all the terms and conditions of the Plan,</li> <li>e) <b>agree to promptly update my Employer and the Plan Administrator on any changes to the status of a Spouse, dependent or beneficiary</b>, and agree that I am liable for any benefit paid out incorrectly in the event that I have not updated my Employer and the Plan Administrator on any change to the status of a Spouse, dependent or beneficiary,</li> <li>f) 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, and</li> <li>g) <b>certify that I have read the information provided on the reverse side of this form.</b></li> </ul>			
SIGNATURE OF MEMBER			DATE
<b>EMPLOYER'S STATEMENT</b>			
NAME OF EMPLOYER		EMPLOYER'S AUTHORIZED SIGNATURE	
EMPLOYEE'S DATE OF EMPLOYMENT (or return to work)	NEW REHIRED <input type="checkbox"/> LATE APPLICANT <input type="checkbox"/>	EMPLOYEE'S CLASS/ DIVISION	EMPLOYEE'S OCCUPATION
EMPLOYEE'S EARNINGS HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/>			HOURS WORKED PER WEEK

**EMPLOYEE IDENTIFICATION**

EMPLOYEE SURNAME	FIRST	INITIAL	SOCIAL INSURANCE NUMBER
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**REFUSAL – WAIVER OF BENEFITS**

I understand the Plan of Group Benefits offered to me. However, if permitted by the provisions of the Plan, I **decline** to participate in:

- Dental     Extended Health (may include Vision Care)     Other (specify) \_\_\_\_\_
- for myself     and/or for my dependents
- Comparable coverage is provided for me and/or my dependents under my Spouse's plan:

Name of Insurer \_\_\_\_\_ Policy No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

I agree that if at a later date I wish to participate in the insurance hereby refused, I must submit, at my own expense, evidence of insurability for myself and any dependents for whom application for coverage is made. However, if I have refused Health/Dental Insurance because of other group coverage, such evidence of insurability will not be required provided the alternate coverage terminates and I apply for Health/Dental Insurance within 31 days of the termination date.

**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:**

*The B.C. Marine Industry Employee 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 with 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.*

**COMMON-LAW DEPENDENTS**

*Common-law spouses and their children **may be** eligible with a minimum co-habitation 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.*

**COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION**

*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.*

**PRIVACY QUESTION**

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.):

Question: \_\_\_\_\_

Answer: \_\_\_\_\_

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](http://www.datownley.com)

**APPLICATION FOR ENROLMENT AND BENEFICIARY DESIGNATION**

**New**    **Revised**

This is a 2 sided form - please complete both pages in ink and print clearly. Please ensure you have signed and dated this form.

**1. APPLICANT DATA**

NAME: Last Name		First Name	Initials	SOCIAL INSURANCE NUMBER	
ADDRESS (PO Box, Unit No. and Street)			CITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER	EMAIL ADDRESS		GENDER Male <input type="checkbox"/> Female <input type="checkbox"/>	DATE OF BIRTH (Year, Month, Day)	
UNION AFFILIATION AND LOCAL NO.	EMPLOYER		DATE OF EMPLOYMENT (Year, Month, Day)		

**2. MARITAL STATUS DECLARATION**

*The person who is your Spouse has important rights under the Pension Plan. If you die before you withdraw your benefits from the Pension Plan, your Spouse may be entitled to a death benefit. If on your pension commencement date you have a Spouse, your pension may have to be paid in a joint survivor form, which will give your Spouse a survivor pension if he/she survives you.*

*Under Federal pension legislation, in relation to a plan member or former plan member, "Spouse" means,*

- (a) *if there is no person described in (b), a person who at the relevant time is married to the plan member or former plan member or who is party to a void or, in Quebec, null marriage with the plan member or former plan member, or*
- (b) *a person who at the relevant time is cohabiting with the plan member or former plan member in a conjugal relationship, having so cohabited with the plan member or former plan member for at least 1 year.*

**If you are not certain about how the definition of Spouse applies to you, please contact the Plan Administrator. The Plan Administrator's contact information is at the top of this page.**

I hereby certify that I have read the above definitions or contacted the Plan Administrator and that **as of the date of this declaration:** (PLEASE CHECK ONE)

- I do not have a Spouse
- I have a Spouse, whose name, birth date and Social Insurance Number is as follows:

Spouse's Last Name:	Spouse's First Name:	Spouse's Social Insurance Number	Spouse's Date of Birth (Year, Month, Day)
_____	_____		

**IF MY MARITAL STATUS CHANGES IN THE FUTURE, I UNDERSTAND I MUST NOTIFY THE PLAN ADMINISTRATOR OF THIS CHANGE.**

### 3. BENEFICIARY DESIGNATION (Please complete this Section even if Section 2 is completed)

This designation applies if you die before you withdraw your benefits from the Pension Plan. If you have a Spouse (as defined in Section 2) on your date of death, the death benefit will be paid to your Spouse, unless a valid written waiver is completed by the Spouse. If you do not have a Spouse at death, or your Spouse signs a waiver, the death benefit will be paid to the beneficiary set out below. If on the date of death you have a former Spouse, he or she may have an interest pursuant to matrimonial property legislation in all or part of the death benefit. This interest may override, in whole or in part, your beneficiary designation.

If I die before I withdraw the benefits that are owing to me under the Pension Plan, I designate the following individual(s) or organization(s) as my beneficiary(ies) and revoke any prior designation I have made:

NAME: Last Name	First Name	Initials	RELATIONSHIP	PERCENT	IMPORTANT NOTES
				%	☞ If you name more than one beneficiary, show percentages. ☞ If beneficiary is a minor, name a Trustee on his/her behalf
				%	
				%	
				%	

If sufficient space is not available on this form for the beneficiary designation desired, check here  and complete a separate sheet to be attached to this form. The attachment should also be signed and dated.

If your beneficiary is a minor, please name an adult Trustee here: \_\_\_\_\_

The Administrator of the Pension Plan shall have no responsibility to monitor the actions of the named Trustee.

**You may change your beneficiary at any time by completing and submitting a new enrolment form to the Plan Administrator. The new form may be obtained from the Plan Administrator or from your Employer.**

### 4. COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The collection, use and disclosure of an individual's personal information by the Board of Trustees of the Pension Plan (or the Trustees' authorized agent, including the Plan Administrator) during his/her participation in the Pension Plan is for the purpose of administering the Pension Plan and the benefits that are conferred on Members of the Pension Plan. The collection, use and disclosure of personal information about individual Members of the Pension 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 Pension Plan.

### 5. PRIVACY QUESTION

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.):

Question: \_\_\_\_\_ Answer: \_\_\_\_\_

### 6. APPLICATION FOR ENROLMENT

I, the undersigned, hereby:

- apply to be enrolled as a Member of the N.D.T. Industry Pension 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 Pension Plan (or its authorized agent) for the purpose of administering the Pension Plan and the benefits that may be conferred on Members of the Pension Plan,
- agree to be bound by all the terms and conditions of the Pension Plan,
- agree to promptly update the Board of Trustees or the Plan Administrator on any changes to the status of a Spouse or beneficiary, and
- agree that I am liable for any benefit paid out incorrectly in the event that I have not updated the Board of Trustees or the Plan Administrator on any change to the status of a Spouse or beneficiary.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF APPLICANT (please print)

**PLEASE SUBMIT COMPLETED FORM TO THE PLAN ADMINISTRATOR:**

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Burnaby, BC V5G 4W6

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