

**INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS & ALLIED WORKERS LOCAL NO. 118 HEALTH AND WELLNESS TRUST FUND** REVISED CARD – CHECK HERE   
**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

<b>MEMBER INFORMATION</b>				
NAME (Surname, Given Name & Initials)			SOCIAL INSURANCE NUMBER	
ADDRESS (No. and Street)		CITY	PROVINCE	POSTAL CODE
TELEPHONE NUMBER	GENDER (Male/Female)	DATE OF BIRTH (Year, Month, Day)	PHARMACARE REGISTRATION NO. (where applicable)	
EMAIL ADDRESS				
I hereby certify that I give permission to contact me by email for Benefit Plan purposes.				
<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 (Surname, Given Name & Initials)	GENDER (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 19, indicate the school they are attending Full-time.</b>				
NAME (Surname, Given Name & Initials)	RELATIONSHIP (Son/Daughter)	DATE OF BIRTH (Year, Month, Day)	STUDENT (Yes/No) and name of school, if over 19	
<b>CO-ORDINATION OF BENEFITS</b>				
Are you covered by another benefit plan (ie your Spouse's plan)? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, indicate the benefits covered: _____ Policy No(s) _____ Insurance Carrier _____				
<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		
				%
				%
If beneficiary is a minor, name adult trustee here >				
<b>APPLICATION FOR ENROLMENT</b>				
I, the undersigned, hereby:				
a) apply to be enrolled as a Member of the International Association of Heat and Frost Insulators & Allied Workers Local No. 118 Health and Wellness Trust Fund,				
b) certify that the information provided on this form is correct,				
c) 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,				
d) agree to be bound by all the terms and conditions of the Plan,				
<b>e) agree to promptly update the Plan Administrator on any changes to the status of a Spouse, dependent or beneficiary,</b>				
f) 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,				
g) 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				
<b>h) understand that the Plan Administrator shall have no responsibility to monitor the actions of a named Trustee on behalf of a minor beneficiary, and</b>				
<b>i) certify that I have read the information provided on the reverse side of this form.</b>				
SIGNATURE OF MEMBER			DATE	

<b>MEMBER INFORMATION</b>	
NAME (Surname, Given Name & Initials)	SOCIAL INSURANCE NUMBER
<b>DEFINITION OF SPOUSE</b> – if you are indicating a spouse on the reverse side (page 1), under MARITAL STATUS DECLARATION, they must meet the following definition:	
<i>The International Association of Heat and Frost Insulators &amp; Allied Workers Local No. 118 Health and Wellness Trust Fund 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>	
<b>COMMON-LAW DEPENDENTS</b>	
<i>Common-law spouses and their children <b>may be</b> 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.</i>	
<b>COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION</b>	
<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>	
<b>PRIVACY QUESTION</b>	
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) [www.hfbenefits.org](http://www.hfbenefits.org)**

**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 Surname		Given Name		Initials	SOCIAL INSURANCE NUMBER
ADDRESS (No. and Street)		CITY		PROVINCE	POSTAL CODE
TELEPHONE NUMBER	GENDER (Male/Female)		DATE OF BIRTH (Year, Month, Day)		
EMAIL ADDRESS	UNION AFFILIATION AND LOCAL NO.		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.*

*The definition of "Spouse" that applies to you depends on the pension legislation in the province in which you work.*

**If you work in British Columbia, you have a Spouse if there is a person who meets the following description:**

*in relation to another person,*

- (a) *a person who, at the relevant time, was married to that other person, and who, if living separate and apart from that other person at the relevant time, did not live separate and apart from that other person for longer than the 2 year period immediately preceding the relevant time, or*
- (b) *if paragraph (a) does not apply, a person who was living and cohabiting with that other person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender, and who had been living and cohabiting in that relationship for a period of at least 2 years immediately preceding the relevant time.*

**If you are working in a different province than British Columbia, you must contact the Plan Administrator to find out the definition of Spouse that applies to you. 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 (Surname, Given 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:

- a) apply to be enrolled as a Member of the Heat and Frost Local 118 Union Pension Plan,
- b) certify that the information provided on this form is correct,
- c) consent to the collection, use and disclosure of my personal information by the Board of Trustees of the Pension Plan (or it's authorized agent) for the purpose of administering the Pension Plan and the benefits that may be conferred on Members of the Pension Plan,
- d) agree to be bound by all the terms and conditions of the Pension Plan,
- e) agree to promptly update the Board of Trustees or the Plan Administrator on any changes to the status of a Spouse or beneficiary, and
- f) 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:**

**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.hfbenefits.org

