Carpenters' Local 27 (Trim Division) Benefit 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 (UNION I.D.)

** 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

Most Recent Date Joined Union

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

Day Month Year

Signature of Local Union Official

MARITAL STATUS

☐ Never married ☐ Divorced ☐ Same Sex Partner ☐ Separated ☐ Civil Union *(for Quebec only)* ☐ Widowed

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

☐ Common Law

Date of Co-habitation: **Day Month Year**

☐ Married

Date of Marriage: **Day Month Year**

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****

Carpenters' Local 27 (Trim Division) Benefit Plan

MEMBER INFORMATION CARD

CO-ORDINATION OF BENEFITS INFORMATION

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

NO ☐ YES ☐

Please provide information for ALL required fields

	* 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 Carpenters' Local 27 (Trim Division) Benefit Plan and designate the person(s) named above as my beneficiary, if then living, to receive any benefits payable under The Carpenters' Local 27 (Trim Division) Benefit 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:

o Revocable o Irrevocable

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

Member's Signature _____ Date _____

THE CARPENTERS' LOCAL 27 (TRIM DIVISION) WELFARE PLAN

MEMBER INFORMATION CHANGE FORM

Please fill in your Last and First Name, as well as your Certificate Number (Union I.D.) and complete ONLY the information that has changed

*Last Name	*First Name	Date of Birth Day Month Year	*Certificate Number

CHANGE IN: HOME / MAILING ADDRESS

Apt	Address	City, Town or Village

Province	Postal Code	Phone ( )	Email:

CHANGE IN: MARITAL STATUS

o Never married o Divorced o Same Sex Partner o Separated o Widowed o Civil Union *(for Quebec only)*

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

o Common Law	o Married
*Date of Co-habitation: Day Month Year	*Date of Marriage: Day Month Year

CHANGE IN: SPOUSAL INFORMATION

Add ☐ Delete ☐	*Last Name	*First Name	Middle Init.	*Date of Birth Day Month Year	Gender: Male o Female o

CO-ORDINATION OF BENEFITS INFORMATION:

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

NO ☐ YES ☐

Please provide information for ALL required fields

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

* Spouse's Insurance Company:

* Policy #:

* Spouse's Coverage Effective Date:

CHANGE IN: DEPENDENT INFORMATION

Add	Change	Delete	*Last Name (if different), * First Name	Gender	*Date of Birth (Day, Month, Year)	Student **	Disabled
o	o	o					
o	o	o					
o	o	o					
o	o	o					
o	o	o					
o	o	o					
o	o	o					

** 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.

PLEASE COMPLETE BOTH SIDES OF THIS FORM
SIGN AND RETURN TO PLAN ADMINISTRATOR

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

CHANGE IN: 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 Carpenters' Local 27 (Trim Division) Benefit Plan and designate the person(s) named above as my beneficiary, if then living, to receive any benefits payable under The Carpenters' Local 27 (Trim Division) Benefit 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:

o Revocable o Irrevocable

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

Member's Signature **Date**