

the individual listed?

BOILERMAKERS' NATIONAL BENEFIT FUNDS (CANADA) - ISO DIVISION

MEMBER INFORMATION FORM

IMPORTANT NOTE: Please fill out this form completely. The information provided on this form will replace information provided on all earlier Member Information Forms or Application Cards. You must notify us of any changes to the information below.

	MEMBE	R'S PE	RSONAI	L INFORMATI	ON								
	NAME: LAST			FIRST / MIDDLE				S	OCIAL I	NSURANCE NU	MBER		
	APT. NO.	NUMBER	/ STREET		CITY			PROVINCE		POSTAI	L CODE		
	EMAIL				TELEPHON	E				☐ Male ☐ Non-binar	Female		
	DATE OF BIRTH LODGE			IRR REGISTRATION #	IBB REGISTRATION # LODGE INITIATION OR LATES				MAI	RITAL STATUS	<u>y</u>		
	MONTH DAY YEAR		NUMBER	NUMBER IS NEGISTRATION."		REINSTATEMENT DATE MONTH DAY YEAR				☐ Widowed			
Please indicate your marital status.	MARITA	L STA	rus										
	If you are married, please provide date of marriage:												
	If you are Separated or Divorced, please provide a copy of your Divorce/Separation Agreement.												
	If you are in a Common-Law relationship, please complete the following statement:												
	I do hereby declar	e that			(spouse's	name - plea	se print) is my	Common-Law Spouse	with who	om I have been coh	abiting		
	since			(date cohab	tation commen	ed) and wh	om I publicly r	epresent as my Spouse	<u>.</u>				
This signature is only required if				(Your Signature)									
member is in a Common-Law relationship.	The definition of C	ommon-Law v	aries across prov	inces. Please see our website	at www.boilerm	akersbenefi	ts.ca/forms for	details.					
	PERSONAL INFORMATION ABOUT MEMBER'S DEPENDANTS - INCLUDING SPOUSE												
Please list your spouse and dependant	Please list Dependants for benefit coverage below. Common-Law spouses are eligible for benefits if they have been living together in a conjugal relationship for 24 consecutive months.												
children under the age of 21, or under	NAME: LAST		FIRST / MIDDLE		DATE OF BIRTH MONTH DAY YEAR			SEX M/F/NB		RELATIONSHIP			
the age of 25 if in attendance at an						.0							
accredited school. Child dependants													
over the age of 25 and incapable of self-													
support may also be covered. Please see													
the <u>benefits booklet</u>													
on the website for details													
If your employer is participating in the Health Plan, please	COORDI	NATIC	ON OF B	ENEFITS									
complete this section.	Is benefit cove	rage availab	ole to you and,	or Dependants from an	other plan(s)	? Yes		No					
If you or your spouse/	If Yes, please provide: Name of individual(s) covered as the member under the other plan(s):												
dependants are covered under any other benefit plan,	Relationship (ie: spouse, ex-spouse, step-parent to my Dependants, guardian to my Dependants):												
please provide the information here	Name of other	plan(s):				·							
Does the other benefit plan provide coverage for your whole family, or just	Family Covera	ge	Single C	Coverage									

COMPLETE BOTH SIDES AND RETURN TO THE PLAN ADMINISTRATION OFFICE



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If your employer is participating in the Health Plan, please complete this section.

The person(s) named as your Health Beneficiary will be the recipient of your life insurance payment (if applicable)

If your employer is participating in the Pension Plan, please complete this section.

The person(s) named as your Pension beneficiary will be the recipient of any remaining pension benefit Upon your death (depending on the option you select when you retire). Please see the pension booklet on the website for details.

The person named as a Trustee will benefits payable on behalf of your beneficiary(ies), if they are under the age of majority at the time of your death (not applicable in Ouebec).

This form requires a witness who is not your spouse or beneficiary to sign where indicated.

Witness Email:

BEINEFICIAI	RY NAME: LAST	FIRST / MIDDLE	RELATIONSHIP	
APT. NO.	NUMBER / STREET	CITY	PROVINCE	POSTAL CODE
the above i	named beneficiary predecea	ses me, my contingent beneficiary is:	TELEPHONE	
_				
no conting	ent beneficiary has been ap	pointed, benefits payable are paid to your Esta	ate.	
TNCION	DENIELCIADY DO	I FDMAN/FDC/ NATIONAL DENGLO	NI FUND (CANADA)	
		ILERMAKERS' NATIONAL PENSIO FIRST / MIDDLE		
3ENEFICIA	RY NAME: LAST	FIRST / MIDDLE	RELATIONSHI	7
PT. NO.	NUMBER / STREET	CITY	PROVINCE	POSTAL CODE
the above i	named beneficiary predecea	ses me, my contingent beneficiary is:	TELEPHONE	
no continge	ent beneficiary has been app	ointed, benefits payable are paid to your Estat	e.	
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n the event o ou designat	of your death, your spouse is e as a beneficiary. Your bene	automatically the first person eligible to recei ficiary will become eligible for benefits only if	ve a pension benefit unless a spou you do not have a spouse on you	usal waiver is on file, no matter wh r date of death.
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Privacy Statement: I authorize the Boilermakers' National Health Plan (Canada), the Boilermakers' National Pension Plan (Canada) (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.

COMPLETE BOTH SIDES AND RETURN TO THE PLAN ADMINISTRATION OFFICE