UFCW LOCAL 401 – REAL CANADIAN SUPERSTORE BENEFIT PLAN REGISTRATION FORM

840

SUITE 101, 46 HOPEWELL WAY NE, CALGARY, AB T3J 5H7
TEL: (403) 250-3534 TOLL-FREE: 1-866-342-3513 FAX: (403) 250-9236 E-MAIL: ufcw401superstore@pbas.ca

☐ NEW MEMBER OR ☐ DATE OF CHANGE _____

SOCIAL INSURANCE NUMBER	LAST NAME (Please Print)	FIRST NAME (Please Print)	INITIAL
– –			

APT. NO. AND STREET ADDRESS / TOWN OR CITY	TELEPHONE/TEXT NUMBER
	( ) -

PROVINCE / POSTAL CODE	EMAIL ADDRESS (Please Print)	PREFERRED COMMUNICATION METHODS
		☐ Email ☐ Text ☐ Regular Mail

DATE OF BIRTH (YEAR MONTH DAY)		DATE OF EMPLOYMENT (YEAR MONTH DAY)	MARITAL STATUS	DATE OF MARITAL STATUS (YEAR MONTH DAY)
			☐ Single ☐ Commonlaw ☐ Divorced ☐ Married ☐ Separated ☐ Widowed	

Cohabitation Clause – You must be cohabiting with a commonlaw spouse for 12 months before their coverage commences. Proof of cohabitation may be requested prior to enrolment.

SPOUSE'S LAST NAME / SPOUSE'S FIRST NAME	DATE OF BIRTH (YR MTH DAY)	DOES SPOUSE HAVE THEIR OWN BENEFIT PLAN?
		☐ No ☐ Yes: Insurer: _____ Policy: _____

DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH (YR MTH DAY)	DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH (YR MTH DAY)
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Overage Dependants - If a dependant is age 19 but under age 25 and in fulltime attendance at an accredited school, annual proof of acceptance/registration must be provided.

LIFE INSURANCE BENEFICIARY	CONTACT INFORMATION FOR LIFE INSURANCE BENEFICIARY

I hereby appoint the above person as my life insurance beneficiary, to receive any Plan proceeds payable by reason of my death. I reserve the right to change my beneficiary, subject to any rules governing beneficiary designation. If my beneficiary predeceases me, and no other has been appointed, the proceeds, if any, shall be payable to my estate.

BEFORE SIGNING THIS CARD, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION", BELOW. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your spouse and dependants. That information comes from this card, the reports your employers and the sponsoring union submit to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Plan Administrator, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express written permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the administrator.

AUTHORIZATION --- I hereby authorize the Trustees and the Plan Administrator to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this card, and coordinate my records with those of the employers and sponsoring union. This authorization will survive as long as personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this card, is true, correct, and complete, to the best of my knowledge and belief, and that I have the consent of my spouse and adult dependants to provide their information as it appears on this card. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Member's Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of my personal information held under the UFCW Local 401 – Real Canadian Superstore Benefit Plan, to (name) _____

at the following address _____ without limitation ☐ or, with the content or purpose limitation(s) specified below ☐.

Content or Purpose Limitation(s): _____

_____

This authorization will be in effect for _____ days from the date shown below ☐ or, is without time limits ☐.

I understand that all personal information will be kept confidential and secure and will be released only for the purpose(s) identified herein, over and above the other purpose(s) to which I have agreed in other documents.

Member's Name: _____

Signed and witnessed at _____ this _____ day of _____ , _____.

Member's Signature: _____ Signature of Witness: _____

IN COMPLYING WITH THIS AUTHORIZATION, THE TRUST FUND ASSUMES NO LIABILITY ASSOCIATED WITH THE RELEASE OF YOUR PERSONAL INFORMATION.