



SECTION 5

Dependent Information				
Name (Last)	(First)	Relationship	Signature	Date of Birth (Mo/Day/Yr)

SECTION 6

***If your dependents have coverage through anyone other than yourself or your current spouse, please complete the following***

Name of Insured Person Providing Coverage: \_\_\_\_\_

Relationship to Dependent: \_\_\_\_\_ Date of Birth of Insured Person (Mo/Day/Yr): \_\_\_\_\_

Employer of Insured Person: \_\_\_\_\_

Which parent/guardian do dependents live with: \_\_\_\_\_

SECTION 7

Declaration of Common-Law Spouse	<i>Please complete if your common-law spouse has not been registered with the Fund office for more than one year</i>
<p>I, _____, do solemnly declare that I consider _____            (Member)            to be my common-law spouse and our relationship as such commenced on the _____ day of _____, 20____,            and has continued to the present time. I make this declaration conscientiously believing it to be true, and knowing            that it is of the same force and effect as if made under oath.</p>	
Participant's signature: _____	<b>PLEASE NOTE: This form must be sworn by a Commissioner for Oaths.</b>
Declared before me at _____ in the Province of _____ this _____ day of _____, 20____.	
Name (please print): _____	
My appointment expires on: _____	
Commissioner for Oaths for the Province of: _____	

SECTION 8

I hereby apply for the benefits for which I am or may become eligible under the group plan ("Benefit Plan") established by my employer. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible, my social insurance number is required for identification and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of my personal information or my spouse and dependents personal information, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally in order to become eligible for and remain a member of the benefit program. I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Please return to:

**Funds Administrative Service Inc.**  
 9<sup>th</sup> floor, 9707-110 Street  
 Edmonton, AB T5K 3T4

Phone: (780) 452-5161 Toll free: 1-800-770-2998