

IRONWORKERS HEALTH & WELFARE TRUST FUND OF WESTERN CANADA
Hints to Help you Complete the Registration/Change of Registration
and Declaration of Beneficiary Form

Section 1 - Member Information

Name: Please provide complete name (surname first, given names second). Please give full given names. Example: Please indicate Edward rather than Ed.

Date of Birth: Please complete in month, day, year order. Example: October 12, 1950 would appear as 10 12 50.

Address: Please provide complete address including postal code. This information ensures that we can send payment of your claims without delays.

Social Insurance Number: Please provide your Social Insurance Number of member.

Section 2 - Spouse's Information

Please indicate if **Spouse** or **Common-Law Spouse**. Please note that a spouse must currently be legally married to the member. A common-law spouse must reside at the same address as the member.

Name: Please provide complete name (surname first, given names second). Please give full given names. Example: please indicate Patricia rather than Pat.

Date of Birth: Please complete in month, day, year order. Example: October 12, 1950 would appear as 10 12 50.

Address: Please provide complete address including postal code.

Section 3 - Spouse's Coverage

This does not refer to the Spouse's coverage through the member's plan

Please indicate whether your spouse has coverage through their employer, does not have coverage through their employer, or is not employed, by checking the appropriate box.

Spouse's Date of Hire: Please provide the date your spouse started work with their employer.

Spouse's Employer: Please provide full name of spouse's employer.

If Spouse's coverage has changed, please provide date spouse left employment and date coverage terminated.

Benefit: ONLY IF YOUR SPOUSE HAS COVERAGE THROUGH THEIR EMPLOYER, please complete the specific benefit information to the right of this section. It is very important that this information be completed in full. The benefits referred to are Drug (which is coverage for prescriptions), Dental (which is coverage for charges from the dentist), Vision (which is coverage for glasses or contact lenses) and Major Medical (which is coverage for hospital charges not covered by Provincial Health plans, and other coverage such as physiotherapy, chiropractor, ambulance services and some medical equipment and supplies).

Single (S) or Family (F): This indicates whether your spouse's coverage is just for themselves or provides coverage for other members of the family. Please indicate "S" if for themselves and "F" if family members are covered.

Effective Date: Please provide the dates which your Spouse's coverage, through their plan, became effective

Section 4 - Beneficiary for Life & Accident Insurance

Name: Please provide the full name of the individual to whom you want your life insurance benefit paid in the event of your death.

Relationship: Please provide the relationship of that person to yourself. Example: Wife, Mother, Friend, Etc.

Address: Please provide the complete mailing address of the individual named. This is required in order for our office to contact them when necessary.

Declaration Appointing Trustee: If the person to receive your life insurance benefits is under the age of 18, please indicate the name of the person who you wish named as Trustee. The Trustee named will be the person responsible for the money on behalf of the under age beneficiary.

Please note, if no beneficiary is named, any life insurance benefits to which you may be entitled, at the time of your death, will be paid to your estate.

PLEASE SEE REVERSE SIDE AS WELL

Section 5 - Dependent Information***Dependents to be covered other than spouse***

Dependents: Please list all of your dependents who should be covered under your Plan. Dependents must be under the age of 25. If between 21 and 25, they must be attending an accredited educational institution on a full-time basis to qualify.

Relationship: Please indicate the relationship of the dependent to the member. Biological children and common-law children may be considered dependents. If the dependent's last name is different from the member's please indicate if they are biological, common-law, step, or adopted dependents. (Common-law dependents must be registered with the Fund office for one year.)

In order for Dependents, other than those noted above, to qualify, the member must have legal guardianship papers from the courts. Example: nephews, nieces and grandchildren cannot qualify unless proof of guardianship is filed with the Fund office.

Date of Birth: Please indicate complete date of birth for each dependent in month, day and year order. Example: October 12, 1980 would be 10 12 80.

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: If your dependents have coverage through anyone other than yourself, or your current spouse, please list that person's name here.

Relationship to Dependent: Please list the relationship of the above individual to the dependent. Example: Natural father, natural mother, etc.

Date of Birth of Insured Person (Month/Day/Year): Please list the date of birth of the person providing the coverage.

Employer of Insured Person: Employer of the person providing coverage.

Which Parent/Guardian do Dependents live with: As the determination of first payer can be influenced by which parent/ guardian has custodial responsibility for the dependent, please advise who the dependent lives with.

Section 7 - Declaration of Common-Law Spouse

Please complete if your common-law spouse has not been registered with the Fund office for more than one year.

If you and your common-law spouse have been residing at the same address for more than one year, but your common-law has not been registered with the Fund office for more than one year, your common-law may be considered eligible for coverage if you complete this Declaration of Common-Law Spouse and have it witnessed by a Commissioner for Oaths.

Please note that the Fund office has Commissioners for Oaths on staff.

If your Spouse has been registered with the Fund office for more than one year, or you have previously completed a Declaration, it is not necessary to recomplete this section.

Section 8

As this is a legal document which is used to determine the eligibility of yourself and your dependents for benefits, it must be completed, dated, and signed in ink in order to be valid.