RETIREE BENEFIT PLAN (60-64) REGISTRATION FORM
PAID BY TRUST FUND

IRONWORKERS' HEALTH & WELFARE
TRUST FUND OF WESTERN CANADA

Please Note: **This Registration Form is a legal document and replaces all previous Registration Forms.**

Complete all sections in ink and sign. Coverage may be suspended pending receipt of a properly completed Registration Form. This form must be returned within 31 days of your date of eligibility.

1. MEMBER INFORMATION

PLAN SPONSOR / EMPLOYER NAME			GROUP NUMBER 6115
LAST NAME	FIRST NAME		CERTIFICATE NUMBER/SIN
GENDER ☐ Male ☐ Female	LANGUAGE ☐ English ☐ French	MARITAL STATUS ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widow	DATE OF BIRTH (MM/DD/YY)
ADDRESS			PHONE NUMBER
CITY	PROVINCE	POSTAL CODE	EMAIL ADDRESS

2. SPOUSE'S INFORMATION

Indicate if: ☐ *spouse or* ☐ *common-law spouse* — *If common-law, you must complete the Declaration below.*

LAST NAME	FIRST NAME		
ADDRESS			
CITY	PROVINCE	POSTAL CODE	PHONE
DATE OF BIRTH (MM/DD/YY)	DATE OF MARRIAGE (MM/DD/YY)	GENDER ☐ MALE ☐ FEMALE	SPOUSE SIGNATURE FOR SUBMITTING CLAIMS

DECLARATION OF COMMON-LAW SPOUSE

Complete if your common-law spouse has not been registered with the fund office for more than one year.

This form must be sworn by a Commissioner for Oaths

I _____ , do solemnly declare that I consider_____ 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.

_____
Member's Signature

Declared before me at _____ in the Province of _____ this ___ day of _____, 20___.

Name (Please Print)_____

My Appointment expires on: _____

Commissioner of Oaths for the Province of: _____

3. Coordination of Benefits

Is your spouse covered under any other health and/or dental plan? ☐YES ☐NO
If yes, name of other Insurer _____

Canadian Life and Health Insurance Association (CLHIA) regulations state: A spouse first claims from their own employer's plan. Children first claim under the parent with the earlier birthday. If parents are separated/divorced, children claim first under the parent with sole custody.

Benefit	Single	Family	None	Effective Date (MM/DD/YY)
Extended Health	☐	☐	☐	
Vision	☐	☐	☐	
Drug	☐	☐	☐	
Dental	☐	☐	☐	

4. Coverage Criteria

1. Please confirm which Local Union office you are a member of: ☐720 ☐725
2. Indicate the number of years of service you have with Local 720 or 725: _____years
3. In receipt of a pension from the Alberta Ironworkers Pension Fund? ☐ Yes ☐ No

5. Union Verification — For Office Use Only

1. Please confirm that this member is in good standing with your Local ☐720 ☐725
2. Indicate the number of years of service with your Local: _____ years

Signature of Union Office Representative _____ Date _____

5. Beneficiary for Life Insurance

Name (Last, First)	Relationship	Date of Birth	% Share

- The Administrator will retain the original beneficiary nomination and all future beneficiary designations. The legal beneficiary is the named beneficiary on file with the Administrator.
- You may wish to consult a legal advisor before designating a beneficiary.
- If no beneficiary is designated, the beneficiary will be your estate.
- If you wish the life insurance proceeds to be divided among two or more beneficiaries, name all of them and indicate their percentage shares, which must total 100%. If one named beneficiary predeceases you, his/her percentage share will be paid to the other beneficiaries pro rata, unless you indicate otherwise.
- If beneficiary is under 18 years of age, please complete Declaration Appointing Trustee.

For Quebec residents only: if you designated your spouse, the designation is irrevocable unless you indicate otherwise. ☐ Revocable

Declaration Appointing Trustee — For beneficiaries under 18 years of age

I do hereby appoint _____ as Trustee to receive any amount due to any beneficiary under 18 years of age and declare the receipt of such Trustee shall be a good discharge to the Insurer for the amount so paid;

And I do hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such minor.

Dated at _____ (city, town) _____ (province) this _____ day of _____, 20 ____ .

_____ **Signature of Witness**

_____ **Signature of Insured**

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 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 of Member **Date** (MM/DD/YY)

Ellement
Pensions | Benefits | Investments

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