HEAT & FROST LOCAL UNION 118 HEALTH AND WELFARE PLAN / HEAT & FROST LOCAL UNION 118 PENSION PLAN

1. Please complete in ink and print clearly. Please fill in all information.
2. LIFE INSURANCE BENEFICIARY - Enter the name of your beneficiary for the Group Life Insurance benefit.
3. PENSION BENEFICIARY - **If you have a Spouse***, you MUST nominate her/him as your pension beneficiary.
   If you do NOT have a Spouse (or can provide a copy of the legal agreement, that waives the spousal entitlement to pension benefits), then you may designate the beneficiary of your choice.

*Spouse means, in relation to a Member:
a) a person who at the relevant time was married to that Member and not living separate and apart from the Member for the 2-year period immediately preceding the relevant time, or,
b) if paragraph (a) does not apply.
   (i) a person who at the relevant time lived with the Member as husband and wife for the 2-year period immediately preceding the relevant time, or
   (ii) a person of the same gender who at the relevant time lived in a marriage-like relationship with the Member for the 2-year period immediately preceding the relevant time.

4. DEPENDENTS - List all eligible dependents including your Spouse**

**Spouse means:
a) a person to whom you are legally married to,
or
b) a person with whom you are living in a Common-Law relationship.

Dependent children: Please list your eldest child first.

5. **For any future changes, a new enrolment card must be completed and can be obtained from your Union office or the Administrator's office.**
6. Please ensure this card is completed in full and is signed and dated. Please forward the completed card to the Administrator:

D.A. TOWNLEY & ASSOCIATES LTD.
101 - 4190 Lougheed Highway, Burnaby, BC V5C 6A8
Phone: (604) 299-7482 Fax: (604) 299-8136 Toll-Free: 1-800-663-1356
www.datownley.com

If you are covered for the Medical Services Plan of BC (MSP) through this Plan, you must complete a separate application or change form to update your MSP coverage.

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ENROLMENT CARD AND BENEFICIARY DESIGNATION

REVISED CARD - CHECK HERE ☐

Please ensure this card is completed in full and that you have signed and dated it. Note: If you are covered for the Medical Services Plan of BC (MSP) through this Plan, you must complete a separate application or change form to update your MSP coverage. When card is fully completed - mail to the Administrator of the Plan.

MEMBER INFORMATION - Please print clearly

SURNAME	FIRST NAME	INIT.	PHARMACARE REGISTRATION NO.

SOCIAL INSURANCE NUMBER	BIRTHDATE (Yr.Mo.Day)	PHONE NUMBER	SEX
		( )	

ADDRESS (No. Street, City, Province, Postal Code)

LIFE INSURANCE BENEFICIARY DESIGNATION RELATIONSHIP
I hereby designate as revocable beneficiary in the event of my death:

PENSION BENEFICIARY DESIGNATION **Please see top of form** RELATIONSHIP
I hereby designate as revocable beneficiary in the event of my death:

To Protect Your Privacy: In order to verify your identity when you call the Administrator, please provide a personal fact or question along with the answer that only you would be able to answer. (i.e., your mother's maiden name, place of birth, etc.)
Question: _____ Answer: _____

I authorize the use of my Social Insurance Number for identification purposes and I understand that D.A. Townley & Associates Ltd. collects personal information to assess eligibility for benefits; to determine and adjudicate benefits; to determine the cost and financially manage these benefits as well as to meet regulatory or contractual requirements and any Trust obligations relating to such benefits and related services provided.

DATE: _____ MEMBER'S SIGNATURE: _____

Completion of this card does not, in itself, entitle a Member to benefits. (Refer to the Plan booklet for details about becoming eligible for benefits)

DEPENDENT INFORMATION - List all eligible dependents

FIRST NAME / SURNAME (if different from Member's)	RELATIONSHIP TO MEMBER	BIRTHDATE (Yr.Mo.Day)	STUDENT Y/N
01 Spouse*			
02 Dependent Children (eldest first)			
03			
04			
05			
06			
07			

CO-ORDINATION OF BENEFITS:

Are you covered by another benefit plan (ie: your Spouse's plan)? ☐ NO ☐ YES
If YES, benefits covered: _____, Spouse's SIN: _____
Policy No (s) _____ Insurance Carrier: _____

If adding a Spouse,
Date of marriage: _____
If adding a Common-Law Spouse,
Date of commencement of Common-Law relationship _____
If adding children over the age of 19, indicate school they are attending full-time:
_____

* Common-Law Spouses and their children **may be** covered with a minimum co-habitation period which is outlined in your group policy.