

ALBERTA REFRIGERATION PENSION PLAN MEMBER INFORMATION FORM

IMPORTANT NOTE: Please fill out this form completely. The information provided on this form will replace information provided on all earlier Application cards or enrolment forms. You must notify us of any changes to the information below.

MEMBER'S PERSONAL INFORMATION

Legal Name: _____ SIN: _____
Last Name Given Names

Address: _____
Number/Street City Province Postal Code

Date of Birth: _____ Phone: _____ Email: _____
mm/dd/yyyy

Sex: Male Female Non-Binary

Marital Status: Single Married Common-Law Divorced Widowed Separated _____
Date of Separation (mm/dd/yyyy)

MARITAL STATUS

If you are married, please provide date of marriage: _____
mm/dd/yyyy

If you are in a Common-Law relationship, please complete the following statement:

I do hereby declare that _____ (spouse's name) is my Common-Law Spouse with whom I have been cohabitating since: _____ (date cohabitation commenced) and whom I publicly represent as my Spouse.
mm/dd/yyyy

Member's Signature: _____ (This signature is only required if member is in a Common-Law relationship.)

PENSION PLAN BENEFICIARY Pension Plan Registration Number: 0546028

Legal Name: _____
Last Name First Name Relationship

Address: _____
Number/Street City Province Postal Code

Phone: _____ Email: _____

If the above beneficiary(ies) predeceases me, my contingent beneficiary is:

Last Name First Name Relationship

If your original and contingent beneficiary(ies) predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

APPOINTMENT OF TRUSTEE – FOR MINOR CHILDREN

I hereby appoint the name listed below as a Trustee to receive any amount(s) payable to any Beneficiary under the Age of Majority.

Name: _____ Relationship: _____

In the event of your death, prior to your retirement, your spouse is automatically the first person eligible to receive a pension benefit unless a spousal waiver is on file, no matter who you designate as a beneficiary. Your beneficiary will become eligible for benefits only if you do not have a spouse on your date of death.

Caution: Your designation of a beneficiary by means of the Member Information Form will not be revoked or changed automatically by any future event (including marriage or divorce) unless required by law or regulation. Should you wish to change your beneficiary, you must do so by completing a new Member Information Form.

CONSENT AND COMPLETION

I understand that my beneficiary designations will not be revoked or changed automatically by any future marriage or divorce, and I understand that I reserve the right to change my beneficiaries at any time by completing a new Member Information Form, subject always to the provisions of any applicable law or regulation. However, if my beneficiary predeceased me and no other has been appointed, such proceeds shall be payable to my Estate. I understand that the Administrator requires my Social Insurance Number for tax purposes, and I hereby consent to the use of my Social Insurance Number by the Administrator for record keeping, reporting and claims purposes.

I consent to the collection, use and disclosure of my personal information.

Signature and Consent: _____ Date: _____
mm/dd/yyyy

Privacy Statement: The Plans will collect, maintain and communicate only the personal information considered necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plan may use and exchange information with relevant persons and organization including the Trustees, legal counsel, institutions, investigative agencies, unions, insurers, re-insurers, health professionals, auditors, legal counsel, actuaries, payroll/payment providers and regulatory authorities in order to manage the plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN MEMBER INFORMATION FORM

IMPORTANT NOTE: Please fill out this form completely. The information provided on this form will replace information provided on all earlier Application cards or enrolment forms. You must notify us of any changes to the information below.

MEMBER'S PERSONAL INFORMATION

Legal Name: _____ SIN: _____
Last Name Given Names

Address: _____
Number/Street City Province Postal Code

Date of Birth: _____ Phone: _____ Email: _____
mm/dd/yyyy

Sex: Male Female Non-Binary

Marital Status: Single Married Common-Law Divorced Widowed Separated _____
Date of Separation (mm/dd/yyyy)

Please indicate your Marital Status

MARITAL STATUS

If you are married, please provide date of marriage: _____
mm/dd/yyyy

If you are in a Common-Law relationship, please complete the following statement:

I do hereby declare that _____ (spouse's name – please print) is my Common-Law Spouse with whom I have been cohabitating since: _____ (date cohabitation commenced)
mm/dd/yyyy and whom I publicly represent as my Spouse.

This signature is only required if member is in a Common-Law relationship.

Member's Signature: _____

COMPLETE INFORMATION FOR SPOUSE/COMMON-LAW SPOUSE AND/OR DEPENDANTS TO BE COVERED FOR BENEFITS, INCLUDING THOSE WITH EXISTING COVERAGE. TO REMOVE ANYONE FROM YOUR BENEFITS, DO NOT LIST THEM.

Please list your spouse and dependant children under the age of 18, or under the age of 25 if in full-time attendance at an accredited school.

NAME		DATE OF BIRTH			SEX	RELATIONSHIP
LAST	FIRST/MIDDLE	MONTH	DAY	YEAR	M / F / NB	

In relation to all children listed, I declare I am in a parent/child relationship and they are solely dependent on me for support. I further declare any step/foster children reside with me full time.

Member's Signature: _____

COORDINATION OF BENEFITS

If you or your spouse/dependants are covered under any other benefit plan, please provide the information here.

Is benefit coverage available to you and/or dependants from another plan(s)? Yes No
 Name of Policyholder: _____ Relationship to Policyholder: _____
(ie: spouse, ex-spouse, stepparent/guardian to my dependants)
 Name of other plan(s): _____ Policy #: _____

Does the other benefit plan provide coverage for your whole family, or just the individual listed.

Effective Date: _____ Family Coverage Single Coverage
 Coverage for: Prescriptions Vision Dental Major Medical Hospital

If coverage has terminated, please provide date of termination: _____

COMPLETE BOTH SIDES AND RETURN TO THE BENEFIT ADMINISTRATION OFFICE

16214 118 Avenue, Edmonton, Alberta T5V 1M6 Ph. 780 452-1331

THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN MEMBER INFORMATION FORM

The person(s) named as your Health Beneficiary will be the recipient of your life insurance payment (if applicable).

HEALTH AND WELFARE PLAN BENEFICIARY Life Insurance and Accidental Death and Dismemberment

Legal Name: _____
Last Name Given Names Relationship

Address: _____
Number/Street City Province Postal Code

Phone: _____ Email: _____

If the above beneficiary(ies) predecease me, my contingent beneficiary is:

_____ Last Name First Name Relationship

If your original and contingent beneficiary(ies) predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

The person named as Trustee will receive any benefits payable on behalf of your beneficiary(ies), if they are under the age of majority at the time of your death (not applicable in Quebec).

APPOINTMENT OF TRUSTEE – FOR MINOR CHILDREN

I hereby appoint the name listed below as a Trustee to receive any amount(s) payable to any Beneficiary under the Age of Majority.

Name: _____ Relationship: _____

Caution: Your designation of a beneficiary by means of the Member Information Form will not be revoked or changed automatically by any future event (including marriage or divorce) unless required by law or regulation. Should you wish to change your beneficiary, you must do so by completing a new Member Information Form.

CONSENT AND COMPLETION

I understand that my beneficiary designations will not be revoked or changed automatically by any future marriage or divorce, and I understand that I reserve the right to change my beneficiaries at any time by completing a new Member Information Form, subject always to the provisions of any applicable law or regulation. However, if my beneficiary predeceased me and no other has been appointed, such proceeds shall be payable to my Estate. I understand that the Administrator requires my Social Insurance Number for tax purposes, and I hereby consent to the use of my Social Insurance Number by the Administrator for record keeping, reporting and claims purposes.

I consent to the collection, use and disclosure of my personal information.

Signature and Consent: _____ Date: _____
mm/dd/yyyy

Privacy Statement: The Plans will collect, maintain and communicate only the personal information considered necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plan may use and exchange information with relevant persons and organization including the Trustees, legal counsel, institutions, investigative agencies, unions, insurers, re-insurers, health professionals, auditors, legal counsel, actuaries, payroll/payment providers and regulatory authorities in order to manage the plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.

COMPLETE BOTH SIDES AND RETURN TO THE BENEFIT ADMINISTRATION OFFICE

16214 118 Avenue, Edmonton, Alberta T5V 1M6 Ph. 780 452-1331