INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS CANADIAN BENEFIT TRUST

SOCIAL INSURANCE NUMBER	LAST NAME (Please Print)	FIRST NAME (Please Print)	INITIAL
– –			

APT. NO. AND STREET ADDRESS	TOWN OR CITY	TELEPHONE NUMBER
		( ) -

PROV POSTAL CODE	UNION INITIATION DATE (YEAR MONTH DAY)	GENDER	DATE OF BIRTH (YEAR MONTH DAY)	MARITAL STATUS
		☐ Female ☐ Male		☐ Married ☐ Single ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

UNION LOCAL NUMBER	UNION MEMBER IDENTIFICATION NUMBER	DATE OF MARRIAGE / COHABITATION (YEAR MONTH DAY)	DATE OF SEPARATION / DIVORCE (YEAR MONTH DAY)
IBEW LOCAL 1007			

EMAIL ADDRESS	DIRECT DEPOSIT INFORMATION (INSTITUTION TRANSIT CODE ACCOUNT NUMBER)

☐ Spouse ☐ Commonlaw SPOUSE'S LAST NAME	SPOUSE'S FIRST NAME	GENDER ☐ Female ☐ Male	SPOUSE'S DATE OF BIRTH (YEAR MONTH DAY)

DEPENDENT'S LAST AND FIRST NAME	GENDER ☐ Female ☐ Male	DATE OF BIRTH (YEAR MTH DAY)	DEPENDENT'S LAST AND FIRST NAME	GENDER ☐ Female ☐ Male	DATE OF BIRTH (YEAR MTH DAY)
DEPENDENT'S LAST AND FIRST NAME	GENDER ☐ Female ☐ Male	DATE OF BIRTH (YEAR MTH DAY)	DEPENDENT'S LAST AND FIRST NAME	GENDER ☐ Female ☐ Male	DATE OF BIRTH (YEAR MTH DAY)

LIFE INSURANCE BENEFICIARY

I hereby appoint (name)_____ who is my (relationship) _____ and who lives at the following address (address) _____ to receive any proceeds that may be payable under the Trust by reason of my death. I reserve the right to change my beneficiary from time to time, subject to complying with the applicable rules governing the designation of beneficiaries. If my beneficiary predeceases me, and no other has been appointed, the proceeds, if any, shall be payable to my estate.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of my personal information held under the International Brotherhood Of Electrical Workers Canadian Benefit Trust ("the Trust"), to the following person (name) _____at the following address _____ without limitation ☐ or, with the content or purpose limitation(s) specified below ☐.

Content or Purpose Limitation(s): _____

_____

This authorization will be in effect for _____ days from the date this registration form was completed ☐ or, is without time limits ☐.

I understand that all personal information will be kept confidential and secure and will be released only for the purpose(s) identified herein, over and above the other purpose(s) to which I have agreed in other documents.

IN COMPLYING WITH THIS AUTHORIZATION, THE TRUST ASSUMES NO LIABILITY ASSOCIATED WITH THE RELEASE OF YOUR PERSONAL INFORMATION.

ADDITIONAL INFORMATION REGARDING YOUR BENEFIT PLAN

LIFE INSURANCE: Participation in the Life Insurance Program is mandatory. The premium and amount of benefit is based on whether you have dependants.
DEPENDANT LIFE: Participation in the Dependant Life Program is mandatory. Members with eligible dependants are automatically enrolled in that program.
LONG-TERM DISABILITY: Participation in the Long-Term Disability Program is mandatory. Your benefit is based on your salary.
MAJOR MEDICAL: Participation in the Major Medical Program is mandatory, unless you have equivalent major medical coverage. If you have equivalent coverage, you may coordinate coverage between this Plan and your other Plan(s). If you have equivalent coverage, you may also waive or reduce the coverage provided under this Plan. To waive or reduce your coverage, select one of the following options: ☐ Single Coverage ☐ Waiving Coverage, initial on this line _____ and provide proof, acceptable to the employer and the administrator, of your equivalent coverage.
DENTAL: Participation in the Dental Program is mandatory, unless you have equivalent dental coverage. If you have equivalent coverage, you may coordinate coverage between this Plan and your other Plan(s). If you have equivalent coverage, you may also waive or reduce the coverage provided under this Plan. To waive or reduce your coverage, select one of the following options: ☐ Single Coverage ☐ Waiving Coverage, initial on this line _____ and provide proof, acceptable to the employer and the administrator, of your equivalent coverage.

BEFORE SIGNING THIS REGISTRATION FORM, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION", BELOW. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you. That information comes from this registration form, the reports your employers and participating unions submit to the Plan, and the claims/applications made for benefit entitlements. It is stored by the administrator of the Plan, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express written permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the administrator.

AUTHORIZATION --- I hereby authorize the Trustees and the administrator of the Plan to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this card, and coordinate my records with those of the employers and participating unions. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this card, is true, correct, and complete, to the best of my knowledge and belief. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Date: _____ Member's Name: _____ Member's Signature: _____

SUITE 101, 2635 – 37TH AVENUE NE, CALGARY, ALBERTA T1Y 5Z6 TEL: (403) 250-3534 FAX: (403) 250-9236 TOLL-FREE 1-855-886-5866