APPLICATION FOR:

LIFE, SHORT TERM DISABILITY, ACCIDENTIAL DEALTH & DISMEMBERMENT, EXTENDED HEALTH, AND DENTAL BENEFITS

ATLANTIC CANADA REGIONAL COUNCIL OF CARPENTERS AND MILLWRIGHTS HEALTH & WELFARE TRUST

☐ NEW ENROLLMENT ☑ CHANGE TO A PREVIOUS ENROLLMENT

PLAN MEMBER INFORMATION:

Last Name	First Name	Second / Other Names	
Address		**Union Local**	**Union Local ID #**
City	**Province** / **Postal Code**	**Email**	**Phone #**
Gender: Male ☐ Female ☐ **Status:** Single ☐ Married ☐ Common Law ☐	**Coverage:** Family ☐ Single ☐	**Social Insurance Number**	**Date of Birth** YY | MM | DD / **Province of Employment**

IF COVERAGE IS "FAMILY" – LIST ALL YOUR DEPENDENTS BELOW:

SPOUSE COVERAGE: Last Name	First Name	Date of Birth YY	MM	DD	Gender M or F

DEPENDENT COVERAGE (IF MORE THAN 3 DEPENDENTS, ATTACH):

RELATIONSHIP CODES: 2 – CHILD UNDER AGE 21; 3 – DISABLED DEPENDENT; 4 – DEPENDENT STUDENT UNDER AGE 25

	Last Name	First Name	Date of Birth YY | MM | DD	Gender M or F	Relationship Code #
1.					
2.					
3.					

COORDINATION OF BENEFITS: DID YOU KNOW THAT YOU CAN RECOVER UP TO 100% OF YOUR EXPENSES IF YOU COORDINATE CLAIMS WITH YOUR SPOUSE'S GROUP PLAN? THIS IS CALLED COORDINATION OF BENEFITS. DO YOU OR YOUR DEPENDENTS HAVE HEALTH AND/OR DENTAL COVERAGE UNDER ANY OTHER INSURER? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING SECTION. BENEFITS WILL BE COORDINATED ACCORDING TO THE INDUSTRY STANDARDS.

Extended Health: ☐ Single ☐ Family Dental: ☐ Single ☐ Family

Spouse Employed by: _____ Insured by: _____ Policy #: _____

BENEFICIARY DESIGNATION FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:

FAILURE TO COMPLETE THE BENEFICIARY DESIGNATION BELOW WILL RESULT IN ANY INSURANCE PROCEEDS PAYABLE IN THE EVENT OF DEATH TO BE PAYABLE TO YOUR ESTATE. THIS SECTION MUST BE COMPLETED IN INK. THE ORIGINAL OF THIS FORM WILL BE REQUIRED FOR A LIFE AND/OR ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM. CROSSED OUT BENEFICIARY DESIGNATIONS MUST BE INITIALED.

	Beneficiary's Last Name	First Name	Date of Birth YY	MM	DD	Relationship	Percentage (must total 100%)
1.							
2.							
3.							

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee, administrator. Do not complete this section if you have already, in any document, made a trustee/administrator appointment which might apply. Consult first with your legal advisor. To receive any amount due for any beneficiary considered a minor under the provincial jurisdiction of residence for designated beneficiaries under 18, I appoint as Trustee: _____.

PRIVACY INFORMATION / CONSENT:

The Atlantic Canada Regional Council of Carpenters and Millwrights Health & Welfare Trust recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the office of the Administrator. We limit access to personal information in your file to the Insurers/Claims Payers or persons authorized by Atlantic Canada Regional Council of Carpenters and Millwrights Health & Welfare Trust who require it to perform their duties, to person to whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

MEMBER SIGNATURE:

I hereby apply for coverage under the group benefits plan issued by Belmont Financial, Medavie Blue Cross and ACE INA Insurance. I hereby revoke any previous beneficiary designations in relation to my forgoing coverage(s) and designate the person(s) named above. I understand that any act that constitutes fraud or intentional misrepresentation of a material fact in answering the questions on this application may result in termination of coverage. I also understand that the Atlantic Canada Regional Council of Carpenters and Millwrights Health & Welfare Trust reserve the right to terminate or amend the Plan should the financial experience dictate that changes are required. I authorize: Belmont Financial, Medavie Blue Cross, and ACE INA Insurance, any healthcare provider, my Plan Administrator, other insurance or reinsurance companies administrators of government benefits or other benefits programs, other organizations, or service providers working with Atlantic Canada Council of Carpenters and Millwrights Health & Welfare Trust to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan. If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorization is valid as the original.

MEMBER'S SIGNATURE: _____ **DATE SIGNED:** _____

RETURN COMPLETED FORM TO BELMONT HEALTH & WEALTH

NEW ADDRESS, effective November 4, 2014

SUITE 605, 133 Prince William Street, Saint John, NB E2L 2B5