Canadian Piping Trades
LOCAL 488

THE EDMONTON PIPE INDUSTRY HEALTH, WELFARE AND PENSION PLANS 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: _____ (Last Name) _____ (Given Names) SIN: _____

Address: _____ (Number/Street) _____ (City) _____ (Province) _____ (Postal Code)

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

Sex: ☐ Male ☐ Female ☐ Non-Binary

Please indicate your Marital Status

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 – please print) is

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

my Common-Law Spouse with whom I have been cohabitating since: _____ (mm/dd/yyyy) (date cohabitation commenced)

and whom I publicly represent as my Spouse.

Member's Signature: _____

PERSONAL INFORMATION ABOUT MEMBER'S DEPENDANTS – INCLUDING SPOUSE

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 dependant 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.

☐ Family Coverage ☐ Single Coverage

Coverage for: ☐ Prescriptions ☐ Vision ☐ Dental ☐ Major Medical ☐ Hospital

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, WELFARE AND PENSION PLANS
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) predeceases me, my contingent beneficiary is:

_____ _____
First Name, Last 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.

If your employer is participating in the Pension Plan, please complete this section.

PENSION PLAN BENEFICIARY Pension Plan Registration Number: 0546028

Legal Name: _____ _____ _____
Last Name | Given Names | Relationship

Address: _____ _____ _____ _____
Number/Street | City | Province | Postal Code

Phone: _____ Email: _____

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

_____ _____
First Name, Last 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.

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.

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