

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: _____ 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.

Member's Signature: _____

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

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.

COMPLETE PERSONAL INFORMATION ABOUT MEMBER'S SPOUSE AND/OR DEPENDANTS TO BE ADDED TO HEALTH & WELFARE BENEFITS

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: _____

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

COORDINATION OF BENEFITS

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 #: _____

☐ Family Coverage ☐ Single Coverage

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

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

COMPLETE BOTH SIDES AND RETURN TO THE BENEFIT ADMINISTRATION OFFICE

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

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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:

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.

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:

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.

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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