LiUNA!care LOCAL 3000 BUILDING HEALTHY FUTURES

MEMBERS APPLICATION

Social Insurance Number	Local 3000 Union Number

This section is to be completed by the plan member. Please print clearly in ink. **Corrections must be clearly crossed out and initialed (no white-out).**

1 Member Information - *Must be completed in full*

Last Name:	First Name:	Middle Name:
Address: City: Province:		Postal Code:
Male: ☐ Female: ☐ Married: ☐ Common Law: ☐ Single: ☐	Date of Marriage/Cohabitation: MM / DD / YYYY	Date of Birth: MM / DD / YYYY
Home Phone #:	Cell #:	Email:
Does your spouse have any other benefits provided under any group insurance? Yes: ☐ No: ☐	Insurance Agency:	Policy #:
Preferred Language:	Preferred Method of Contact : Letter: ☐ Email: ☐ Phone: ☐	

2 Dependent Information (Spouse) - *Must be completed in full, if applicable.*

This section is to be completed by the plan member. If you wish to cover your eligible dependents, please list your dependents by completing the following section. **Corrections must be clearly crossed out and initialed (no white-out).**

Last Name:	First Name:	Middle Initial:	Male: ☐ Female: ☐	Date of Birth: MM / DD / YYYY

What group benefits does your spouse have through their employer? Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

Married: ☐ Common Law: ☐	Health Care: Yes: ☐ No: ☐	Vision Care: Yes: ☐ No: ☐	Dental Care: Yes: ☐ No: ☐

2 Dependent Children - *Must be completed in full, if applicable.*

Last Name	First Name	Middle Initial	Date of Birth	Sex	Full Time Student	Disabled Dependent	Member Relationship
			MM / DD / YYYY	-	-	-	
			MM / DD / YYYY	-	-	-	
			MM / DD / YYYY	-	-	-	
			MM / DD / YYYY	-	-	-	

3 Group Life Insurance Beneficiary - *Must be completed in full*

This section must be completed to designate a beneficiary for your life benefits. The original of this form will be required for a life claim. **Corrections must be clearly crossed out and initialed (no white-out).**

Full Legal Name (First/Middle Initial/Last)	Date of Birth	Address	Phone #	% Allocated	Member Relationship
	MM / DD / YYYY				
	MM / DD / YYYY				
	MM / DD / YYYY				

4 Member Signature

Signature: _____ Date: MM / DD / YYYY

CLEAR FORM

DEPENDENTS

A dependent spouse or common law to be eligible as your dependent must be residing at the same address as the member for a period of 1 year or more to qualify for benefits or joined by virtue of a valid civil or religious ceremony.

Dependent children must be age 20 years of age or younger (children from 21 years of age but under age 25) will be covered provided they are attending an accredited school, college, or university as a full time student provided annual proof of student registration is submitted.

COLLECTION OF PERSONAL INFORMATION

Benefit Plan Administrators Limited (BPA) on behalf of the Trust Fund collects personal information from you, your employer or your former employer, and your union local, to determine your eligibility and benefit entitlements under your plan. Your employment history may be shared with your union for the purpose or monitoring the contributions required to be made under the terms or the Collective Agreement. Your personal information is kept confidential and safeguarded. BPA will only release relevant personal information to your eligible dependents specific to their benefit entitlements. Your personal information (and the personal information of your dependents) may be disclosed to insurance carriers, auditors and other benefit providers so that they can perform services in connection with the administration on the Plan. Disclosure will be limited to the specific information required for a particular purpose. Personal information may also be disclosed as required or permitted by law. I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above. I hereby apply for participation in the Trust Fund. I appoint the following beneficiary with respect to any Group Life Insurance proceeds to which designated beneficiary may become entitled and I reserve the right to change the beneficiary from to time, subject always to the provisions of any law or government regulations governing designation of beneficiaries in force from time to time. If the named beneficiary predeceases me and no other has been appointed, such proceeds shall be payable to my Estate.

Please complete all sections in detail and sign Section 4 of this application. Any benefits to which you may be entitled under your Benefit Plan may not be paid until this card is completed, dated, signed and filed with the Plan Administrator. A new card is required to change any information. Corrections must be clearly crossed out and initialed (no white-out).

Please Return Original Application Card to:
LiUNAcare Local 3000
90 Burnhamthorpe Rd West Suite 300
Mississauga, ON L5B 3C3

Contact Us:
Phone: 905-247-3040
Website: www.liunacare3000.com
Email: info@liunacare3000.com