



**International Alliance of Theatrical Stage Employees
Local 667 & 669 – Policy 164609
Health and Welfare Plan Application Form**



Plan Member Information:

This section is to be completed by the Plan Member.

Please print the entire form clearly in INK.

Plan Member Name (print): _____
Last Name First Name Middle Initial

Address: _____

City: _____ Province: _____ Postal Code: _____

Social Insurance Number: _____ Gender: Male Female

Date of Birth: Month: _____ Day: _____ Year: _____ Status: Single Married / Common Law / Civil Union

Dependent Information

This section is to be completed by the Plan Member.

	Last Name	First Name	Date of Birth			Gender M/F	Full time student 21-25 Y/N	Disabled dependent Y/N
			month	day	Year			
Spouse:	_____	_____	____	____	____	____	____	____
Child:	_____	_____	____	____	____	____	____	____
Child:	_____	_____	____	____	____	____	____	____
Child:	_____	_____	____	____	____	____	____	____
Child:	_____	_____	____	____	____	____	____	____

NOTE: When enrolling a common-law or same sex spouse, indicate commencement date of co-habitation:

Month: _____ Day: _____ Year: _____

Full-time Student (21-25) Information:

This section is to be completed by the Plan Member.

You must apply for coverage for each child who has reached or is about to reach the age limit of 21, who is a full time student and solely dependent on you for support.

	Last Name	First Name	Date of Enrollment (from)			Date of Enrollment (to)		
			month	day	year	month	day	year
Student:	_____	_____	____	____	____	____	____	____
Student:	_____	_____	____	____	____	____	____	____
Student:	_____	_____	____	____	____	____	____	____

NOTE: Proof of education must be provided at the beginning of each semester and/or the beginning of each academic year for coverage to continue for a student who is age 21 to 25 (or age 26 if you reside in the province of QC).

Co-ordination of Benefits:

This section is to be completed by the Plan Member.

Complete this section if your dependent spouse has benefit coverage under another group plan.

My spouse has or will have benefit coverage under another group plan for the benefits indicated below:

Insurance Company: _____

Policy Number: _____

Certificate Number: _____

HEALTHCARE	DENTALCARE	VISIONCARE	PRESCRIPTION DRUGS
Single <input type="checkbox"/>	Single <input type="checkbox"/>	Single <input type="checkbox"/>	Single <input type="checkbox"/>
Family <input type="checkbox"/>	Family <input type="checkbox"/>	Family <input type="checkbox"/>	Family <input type="checkbox"/>

Beneficiary Appointment

This section is to be completed by the Plan Member.

This section must be completed to designate a beneficiary for your life insurance benefits.

The original of this form will be required for a life claim.

Crossed out beneficiaries must be initialed.

Beneficiary's Name(s)

Last Name	First Name	Percent allocated	Relationship to Plan Member
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To be divided as follows: As per the percentages indicated above, or in equal shares to the survivors

If your Beneficiary is a minor or lacks legal capacity, please complete the following:

I hereby appoint _____ as Trustee to receive and to hold in trust any amount due to any beneficiary under 18 years of age, or lacks legal capacity, and declare the receipt of such Trustee shall be a good discharge to the Insurance Company for the amount so paid. Please provide full contact information of Trustee.

You may change this beneficiary designation at any time upon notice to the Plan office. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) you must notify the Plan office.

Note: Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked 'Revocable' below.
I hereby make the above beneficiary designation:
 Revocable, I may change this beneficiary at any time.

Privacy

This section explains the Fund's & GWL's commitment to privacy.

Protecting Your Personal Information

At the IATSE Local 667/669 Health & Welfare Fund Office, and Great West Life Assurance Company (Great West Life) we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept at the Fund office. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending us a request in writing. We limit the access to personal information in your file with the Fund office to Fund staff or persons authorized by the Fund who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purpose of determining your eligibility for coverage and administering the group benefit plan. This includes investigating and assessing claims, and creating and maintaining records concerning your relationship to the Fund. For a copy of the Fund Privacy Policy please refer to www.iatse667-669healthplan.com. For a copy of Great West Life's Privacy Guidelines or if you have any questions please visit the Great West Life website at www.greatwestlife.com.

Authorizations and Declarations

This section must be signed and dated in INK by the Plan Member

I hereby apply for coverage under the group benefits plan issued by the IATSE Local 667/669 Health & Welfare Fund. I have read and understand and agree with the contents of the section of this form entitled 'Protecting Your Personal Information'. I authorize the IATSE Local 667/669 Health & Welfare Fund, 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 the IATSE Local 667/669 Health & Welfare Fund or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan. I hereby consent to the **use of my social insurance number when applicable, and the use of personal information** by the Health & Welfare Fund, the Board of Trustees of the Fund and their agents to be used for the purposes of recordkeeping and the administration of the Plan.

If applying for coverage of 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 the 'Authorization and Declarations' section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge. For Quebec applicants: I request that this form be in English. Je demande que ce formulaire me soit remis en anglais.

Plan Member signature: _____ Month: _____ Day: _____ Year: _____

Upon completion please return this application to one of the following offices

IATSE Local 667 9 Gloucester St. Toronto, ON M4Y-1L8 416-368-0072	IATSE Local 667 469, rue Jean-Talon Ouest Montréal, QC H3N 1R4 514-937-3667	IATSE Local 669 217-3823 Henning Drive Burnaby, BC V5C-6P3 778-330-1669	IATSE 667/669 H & W Office 217-3823 Henning Drive Burnaby, BC V5C-6P3 778-392-4455 / 866-366-9667
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