



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



Please complete both sides of this form, where applicable. PLEASE PRINT.

1. MEMBER INFORMATION (must be completed):

Legal Name: _____
last name given names

Address: _____
apt. no. number/street city province postal code

Province of Residence (if not above address): _____

Social Insurance Number: _____ Date of Birth: _____
month day year

Sex: Male Female Status: Single Married Common Law Divorced
 Widow Separated

2. FAMILY MEMBERS TO BE COVERED (complete if applicable & please include your spouse)

| | Legal Last Name | Given Names | Date of Birth | | | Sex M/F | Relationship |
|---------|-----------------|-------------|---------------|-----|------|------------|--------------|
| | | | month | day | year | | |
| Spouse: | | | | | | | |
| Child: | | | | | | | |
| Child: | | | | | | | |
| Child: | | | | | | | |
| Child: | | | | | | | |

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

3. PLEASE COMPLETE FOR DEPENDENT CHILDREN WHO ARE ATTENDING FULL TIME SCHOOL, AGE 21 to 25 (if applicable):

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. **Complete for each over-age child who is a student (i.e who is age 21 or over):**

| Student's Name | Name of School <i>Please attach proof of enrollment</i> | Effective Date of Enrollment | | | | | |
|----------------|--|------------------------------|-----|------|---------------|-----|------|
| | | Effective From: | | | Effective To: | | |
| | | month | day | year | month | day | year |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

You must re-apply at the beginning of each academic year for coverage to continue for a student who is age 21 to 24.

Both sides of this form must be completed

4. COORDINATION OF BENEFITS ENROLLMENT (complete where applicable):

If you have benefits in a plan other than the I.A.T.S.E., Local 667/669 Health & Welfare Benefits, please indicate accordingly and complete the following section:

- 1. My spouse has or will have benefit coverage under another group plan for the benefits indicated below:
- 2. I have or will have benefit coverage under another group plan other than the I.A.T.S.E., Local 667/669 Health & Welfare Benefits for the benefits indicated below:

NOTE: If you chose #1 or #2, you must fully complete this section of the form

| Benefit | Indicate coverage (Y or N) | Single or Family (S or F) | Effective Date of Alternate Coverage | | | Insurance Company & Group Number |
|--------------------|----------------------------|---------------------------|--------------------------------------|-----|------|----------------------------------|
| | | | month | day | year | |
| Prescription Drugs | | | | | | |
| Major Medical | | | | | | |
| Hospital Room | | | | | | |
| Vision Care | | | | | | |
| Out of Country | | | | | | |
| Dental | | | | | | |

5. BENEFICIARY APPOINTMENT* (must be completed):

I hereby appoint the following as my Beneficiary (or Beneficiaries) to receive any benefits payable in the event of my death:

Legal Name: _____ Relationship to Member: _____
last name given names

Address: _____
apt. no. number/street city province postal code

If your Beneficiary is a minor, please complete the following: I hereby appoint _____ as Trustee to receive any amount due to any beneficiary under 18 years of age, and declare the receipt of such Trustee shall be a good discharge to the Insurance Company for the amount so paid.

** The appointment of any beneficiary is revocable unless you are a resident of Quebec in which case the appointment of a spouse as beneficiary is irrevocable unless designated revocable. If you are not a resident of Quebec any appointment is revocable unless designated irrevocable. The appointment shall apply to all benefits for which the appointment is provided under the Plan.*

6. MEMBER DECLARATION (must be completed):

If the above named Beneficiary (or Beneficiaries) predeceases me, and no other Beneficiary has been appointed, any benefits that are payable shall be payable to my estate. Subject to the provisions of any law or government regulation which applies, I reserve the right to change my Beneficiary under the above noted Plan and my appointment of a new Beneficiary shall automatically revoke any previous appointment of Beneficiary which I have made. I understand that it is my responsibility to advise the Administration Office in writing, of any changes with respect to the status of my spouse, or Dependents, and to make any necessary redesignation of Beneficiary.

I hereby apply for membership in the above named Plan and agree to abide by the terms and conditions thereof. I hereby consent to the **use of my social insurance number when applicable, and the use of personal information** by the Health & Welfare Plan, the Board of Trustees of the Plan and their agents to be used for the purposes of recordkeeping and the administration of the Plan.

Dated this _____ day of _____, 20 _____

 Legal Signature of Member

 Signature of Witness (someone other than a beneficiary)

 Name of Witness (please print)

PLEASE COMPLETE AND RETURN to either the Local 667 or Local 669 Office:

I.A.T.S.E., Local 667
 3177 rue St. Jacques, Bureau 201
 Montreal, QC H4C 1G7
 (514) 937-3667

I.A.T.S.E., Local 667
 9 Gloucester St
 Toronto, ON M4Y 1L8
 (416) 368-0072

I.A.T.S.E. Local 667/669 Health & Welfare Office
 3823 Henning Dr #217
 Burnaby B.C. V5C 6P3
 1 (866) 366-9667 or (778) 329-4455

I.A.T.S.E., Local 669
 3823 Henning Dr #217
 Burnaby B.C. V5C 6P3
 (778) 330-1669

Both Sides of This Form Must Be Completed