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

This form must be completed by the Plan Member.
Please print clearly in ink. If using a fillable form, your original signature must be in ink.

Plan Member Information

*Gender currently, for the purposes of administration by Canada Life.

This is a mandatory field so please choose one.

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

Address: ______________________________

City: ______________ Province: ________ Postal Code: ______________

Social Insurance Number: ______________ Gender: ☐ Male ☐ Female ☐ Other ☐ Undisclosed

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

Dependent Information

Dependent coverage is for your children up to age 21, or aged 21-25 (26 in Quebec) if that child is a full-time student and solely dependent on you for support. Include the names of all of your dependent children in this section and for those who are full-time students aged 21-25 and reliant solely on you for support, further information as indicated will be required.

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

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

Month: ______ Day: ______ Year: ______

NOTE: If you have indicated that one or more of your dependent children is a full time student, when you return this form, please include, on a separate piece of paper, proof of full time enrolment in an educational institute and the dates during which your child will be in attendance as a student. Proof of enrolment as a full time student must be provided at the beginning of each semester and/or the beginning of each academic year for dependent coverage to continue until age 25 (26 if you reside in the province of QC)

Co-ordination of Benefits:

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:

HEALTHCARE		DENTALCARE		VISIONCARE		PRESCRIPTION DRUGS	
Single	Family	Single	Family	Single	Family	Single	Family
☐	☐	☐	☐	☐	☐	☐	☐

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

IATSE 667/669 H & W Plan Office
122-3823 Henning Drive
Burnaby BC V5C-6P3

IATSE Local 669
217-3823 Henning Drive
Burnaby BC V5C-6P3

IATSE Local 667
229 Wallace Avenue
Toronto ON M6H-1V5

Beneficiary Appointment

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

Crossed out beneficiaries must be initialed by the Plan Member in ink.

Beneficiary Appointment for Your Life Benefits

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

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.

For Quebec Applicants only – Benefits payable under this Plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and **the insurer** has been provided notice of the trust. If a valid trust has already been established, designate the trust as beneficiary in this section. **Before designating a trust, you should seek legal advice.**

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

I hereby appoint ____
Trustee Last Name First Name Middle Initial Relationship to plan member

as Trustee to receive and to hold in trust any amount due to any beneficiary under 18 years of age, or who lacks legal capacity, and declare the receipt of such Trustee shall be a good discharge to the insurance company for the amount so paid. **Before designating a trustee you should seek legal advice.** Please provide full contact information of the Trustee:

____
Trustee Home Phone Number Cellular Phone Number E-mail Address

Privacy

This section explains our commitment to your privacy.

Protecting Your Personal Information

We recognize and respect the importance of privacy. When you apply for coverage under the IATSE 667 & 669 Plan (the "Plan"), we establish a confidential file that contains your personal information, including the information contained on this form. This file is kept in the Plan Office and the information may be shared with the Plan's insurer or other benefit providers in order to process your claims for benefits. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to the Plan Office. Coverage under the plan may involve the use of service providers located within Canada or outside of Canada, and it may be necessary to disclose your personal information to them in respect of your claims. We limit the access to personal information in your file to persons authorized under the Plan who require it to perform their duties, including the insurer or other benefit providers, 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 Canada or outside of Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the Plan. This includes investigating and assessing claims, and creating and maintaining records concerning your coverage under the Plan. Your social insurance number is part of your personal information but is subject to special treatment. Your social insurance number will be used by the Plan Office solely for tax reporting purposes as required by law and to ensure that contributions remitted on your behalf are credited to you. For a copy of the Fund Privacy Policy please visit www.iatse667-669healthplan.com and click the link at the bottom of the home page. You can also access a copy of the privacy guidelines in place with the Plan's insurer or other benefit providers at the Plan's website or by contacting the Plan Office.

Authorizations and Declarations

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

I hereby apply for coverage under the IATSE Local 667 & 669 Health & Welfare Plan. I have read and understand and agree with the contents of the section of this form above entitled 'Protecting Your Personal Information'. I authorize the IATSE Local 667 & 669 Health & Welfare Plan, the Plan's administrator, the Plan's insurer and other service providers, administrators of government benefits or other benefits programs, and other insurers and organizations, 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** for tax reporting purposes as required by law and if necessary to allow the Plan Office or its assigns to ensure contributions remitted on my behalf are credited to me for the purposes of coverage in 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 Declaration' 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 accept that this form is in English. Je reconnais que ce formulaire est en anglais.

Plan Member signature:______________________Month:__________Day:__________Year:__________