MAXIMUM Benefit.

JG10

ENROLMENT APPLICATION

For office use only | Effective Date | Certificate #

To be Completed by ~~Employer~~ UNION (Please print clearly in INK)

1

Firm/Company Name IUPAT LOCAL 177 WELFARE TRUST FUND					Firm/Division #
Division Name					Class
Date of Full Time Employment (YYYY/MM/DD)				Employee Occupation	
Regular Earnings $	Frequency	☐ Annually ☐ Bi-Weekly	☐ Weekly ☐ Semi-Monthly	☐ Monthly ☐ Hourly	If hourly, # hours/week
Authorized Signature					Date (YYYY/MM/DD)

Employee Information (To be completed by the employee – please print clearly in INK)

2

Employee Name (Last)	(First)	(Initial)	
Gender ☐ Male ☐ Female	Date of Birth (YYYY/MM/DD)	Language of Preference ☐ English ☐ French	
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-Law: Date Started Living Together (YYYY/MM/DD)			
Address (Number, Street, Apt. Number)			
City	Province	Postal Code	

Dependent Information

List your spouse and children below (please print clearly in INK)

3

Dependent's Name (Last, First) Include last name if different from your last name	Date of birth (YYYY/MM/DD)	Gender	Relationship to Employee*
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Coverage under your Provincial Health plan is necessary in order for you and your dependents to be eligible for Extended Health coverage.

*If an over age dependent is disabled, please complete the *Request for Over Age Disabled Dependent Coverage* form. If a dependent is an over age dependent, please complete the *Request for Over Age Dependent Coverage* form. Please see your Plan Administrator for details.

Waiver of Coverage Requested

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You may waive Extended Health Care and Dental Care Benefits for yourself and your dependent(s) ONLY if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have waived but certain restrictions may apply. *Please see your Plan Administrator for details.*

I waive coverage for:

Myself and my dependents under ☐ Extended Health Care ☐ Dental Care

My dependents only under ☐ Extended Health Care ☐ Dental Care

Spouse's Insurer's Name _____ Plan Number _____

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Spousal Information for Co-ordination of Benefits (If you do not have a spouse, please disregard this section.)

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Spouse's Gender	Spouse's Date of Birth
☐ Male ☐ Female	Date (YYYY/MM/DD)

Spousal Health Coverage		Spousal Dental Coverage	
Does your spouse have health care coverage under his/her own plan?		Does your spouse have dental care coverage under his/her own plan?	
☐ No	Effective Date of Coverage	☐ No	Effective Date of Coverage
☐ Yes: Name of Other Insurer		☐ Yes: Name of Other Insurer	
Spouse's Plan Covers:		**Spouse's Plan Covers:**	
☐ Your Spouse Only	☐ Your Spouse & Yourself Only	☐ Your Spouse Only	☐ Your Spouse & Yourself Only
☐ Your Spouse & Children Only	☐ Your Spouse, Yourself & Your Children	☐ Your Spouse & Children Only	☐ Your Spouse, Yourself & Your Children

Beneficiary Designation – Please print clearly in INK (crossed out or revised information must be initialled by the employee)

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

6

Last Name	First Name	Middle Initial	% of Benefit	Relationship to Employee

Divided: ☐ As per percentages above (must total 100%) ☐ In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here: ☐ Revocable, I may change this designation at any time

Trustee/Administrator Designation

If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name _____ Relationship to Employee _____

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

For Quebec Only: Where this appointment is governed by Quebec law, "trustee" shall be read as "administrator", and all terms interpreted accordingly. The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

Employee Signature (Please sign and date here)

Declaration and Authorization for the Collection and Communication of Personal Information

I hereby apply for Group Insurance for which I am, or may become, eligible under this plan and authorize any required payroll deductions for administration of my benefits. All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that I have no other coverage under the Maximum Benefit Plan and have not applied for any. I understand that I must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage. I acknowledge that no benefits will be payable until the insurer approves this application.

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I authorize Maximum Benefit to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

A photocopy or electronic version of this Declaration and Authorization is as valid as the original.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Signature of Employee _____ Date _____

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AUTHORIZATION FOR DIRECT DEPOSIT

Employee Information

Firm Name **IUPAT Local 177 Welfare Trust Fund**	Firm Number
Employee Name (last, first)	Certificate Number
Street Address	Date of Birth (DD/MM/YYYY)
City Province Postal Code	

PLEASE ATTACH A SAMPLE CHEQUE, MARKED "VOID"

I hereby authorize Maximum Benefit to direct deposit benefit payments to my account. This authorization may be cancelled at any time by written request. I have attached a sample cheque marked "void" for banking information purposes. I understand that I will receive an Explanation of Benefits, via mail, explaining the adjudication of each claim.

Employee Signature _____ Date _____

The account you choose must have chequing privileges.
Your request can not be processed if a sample cheque is not provided.

Complete this request (attaching your "voided" cheque) and submit to:

IUPAT Local 177 Welfare Trust Fund
17804 – 118 Avenue NW, Edmonton, AB T5S 2W3