USW-Coastal Forest Industry Health & Welfare Plan / FIR Labour Relations Limited Extended Health and Dental Plans

JOINT ENROLMENT FORM

☐ New Member ☐ Reinstatement ☐ Change of Information

MEMBERS – Please complete Parts 2 through 7 of this application. NOTE: There is no provision to waive coverage. In accordance with the Collective Agreement, full participation in all plans under the Collective Agreement is to be a condition of employment for all eligible employees.	**EMPLOYER / PLAN ADMINISTRATOR –** Please complete Part 1 of this application.

PLEASE PRINT CLEARLY IN INK. Sign, date and submit your application as soon as possible.

1. EMPLOYER / PLAN ADMINISTRATOR

Name of company/employer			**Division Name/ Subdivision Name**		**Employer Account Code** (if applicable)
Division #	**Sub-division #** (if applicable)	**Class #**	**Plan Code** (if applicable)	**Union Local** ☐ 1-1937 ☐ 2009 ☐ Other	**EHC/Dental Policy Number** ☐ 8944 ☐ Other _____
EHC/Dental Member ID (system generated)		**Job Title**		**Employment Type** ☐ Full Time	**Hours per week** / **Date of full-time hire or rehire** (MM-DD-YYYY)
Qualifying period date (MM-DD-YYYY)		**Life/AD&D/WI effective date** (MM-DD-YYYY)		**EHC effective date** (MM-DD-YYYY)	**Dental effective date** (MM-DD-YYYY)
Employer's Authorized Signature		**Date** (MM-DD-YYYY)	**Contact information for person completing Part 1** **Name** **Phone** **Email Address**		

2. MEMBER INFORMATION

Legal First Name	**Middle Initial**	**Last Name**	**Birthdate** (MM-DD-YYYY)	**Sex** ☐ Male ☐ Female	**Social Insurance Number**
Street Address (include unit number if applicable)			**City**	**Province**	**Postal Code**
Email Address		**Name of last employer** (if you were covered by this Plan or another USW-Forest Industry Plan)			**Last employer Account Code** (if applicable)

3. SPOUSE INFORMATION – list your eligible spouse for Extended Health and Dental coverage for benefits under FIR LABOUR RELATIONS LIMITED EXTENDED HEALTH AND DENTAL PLAN

Legal First Name	**Middle Initial**	**Last Name**	**Birthdate** (MM-DD-YYYY)	**Sex**	**Relationship to You**	**Date of Marriage or Date of Cohabitation**
				☐ Male ☐ Female	☐ Common-Law ☐ Married	

4. DEPENDENT CHILDREN – list your eligible children for Extended Health and Dental coverage for benefits under FIR LABOUR RELATIONS LIMITED EXTENDED HEALTH AND DENTAL PLAN

Legal First Name	**Middle Initial**	**Last Name**	**Birthdate** (MM-DD-YYYY)	**Sex**	**Full Time Student***	**Dependent(s) With Disabilities****
First child				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Second child				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Third child				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Fourth child				☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

* Dependent Children must be financially dependent on you & must not be married or in any other formal union. A student is an overage Dependent who is a full-time student attending an educational institution recognized by Canada Revenue Agency

** Dependent(s) With Disabilities additional information required - Provide a copy of one of the following with completed enrolment form: a) CRA approved Application for Disability Tax Credit OR b) Persons with Disability CRA approval letter OR c) Disabled Dependent Application (obtain from your Plan Administrator)

Continued on the next page…

5. LIFE INSURANCE and ACCIDENTAL DEATH BENEFICIARY DESIGNATION for benefits under USW-COASTAL FOREST INDUSTRY HEALTH & WELFARE PLAN

By completing this section, I revoke all prior beneficiary designations and designate the following individuals as my revocable beneficiary(s) in the event of my death, where permitted by law. A revocable nomination can be changed at any time without the beneficiary's consent.

Designate at least one beneficiary. If you do not designate a beneficiary, these benefits will be paid to your estate in the event of your death. If you make an error, sign or initial beside the correction. For residents of the Province of Quebec, the designation of a spouse is irrevocable unless otherwise specified. If share of proceeds for multiple beneficiaries is not indicated, the share will be split evenly between the listed beneficiaries. If you are nominating a beneficiary who is a minor, please complete the Trustee Appointment in Section 6.

Legal First Name	Middle Initial	Last Name	Relationship to You	Share %

6. TRUSTEE APPOINTMENT (Complete ONLY If any Designated Beneficiary Is under the age of majority)

If you wish to designate minor children as beneficiaries, it is important to also appoint a trustee. A minor is a child who has not yet reached the age of majority as defined by provincial legislation.

Any payments becoming due while the beneficiary(s) are a minor are to be made to:_____
as trustee, or failing such trustee, to the duly appointed guardian of such minor child as trustee. The Plan Administrator shall have no responsibility to monitor the actions of the named trustee.

7. DECLARATION OF UNDERSTANDING and CONSENT

I, the undersigned, hereby apply to be enrolled as a member of the USW-Coastal Forest Industry Health & Welfare Plan and, if applicable, the FIR Labour Relations Limited Extended Health and Dental Plan (collectively referred to as "the Plans"). I understand that completion of this form does not in itself entitle me to benefits under either of the Plans– qualification for benefits is in accordance with the rules of the Plans.

I agree to the terms and conditions of the Plans and authorize my employer to deduct the required contributions (if any) from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse the Plans up to the amount advanced to me pending such settlement or judgement. I consent to the Plan Administrators, Pacific Blue Cross and AGA Benefit Solutions, collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrolment or coverage under the Plans.

I consent to the disclosure of my personal information to the Trustees of the USW-Coastal Forest Industry Health & Welfare Plan and to FIR Labour Relations Limited and their authorized agents and representatives (including the Plan Administrators AGA Benefit Solutions and Pacific Blue Cross) for the purposes of assessing and providing benefits coverage. I also consent to the collection, use, and disclosure of my personal information and that of my dependents for the purposes of conducting inquiries or investigations to verify claims, and to ensure that my dental, pharmacy, and other health service providers, dependents, or I have not made fraudulent or misleading claims or claims to which my dependents or I may not be entitled. I further agree that if it is found that my dependents or I participated in a false or misleading claim or made a claim or received benefits for which my dependents or I are not entitled, that the Plan Administrators may suspend our coverage, recover such amounts wrongly paid to me, and /or exercise the right of set-off.

I consent to the use of my social insurance number for tax and/or other statutory reporting purposes and as an identification number where it is required in the administration of the plan.

I also consent to the disclosure of my personal information to my employer when required or permitted by law or by contract between AGA Benefit Solutions and/or Pacific Blue Cross and my employer; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy and AGA Benefit Solutions privacy policy.

I give permission to contact me by email for purposes related to the Plans.

Members' Signature _____ Date Signed _____

Send completed form to the Plan Administrators:

PO Box 24715 Stn F
Vancouver BC Canada V5N 5T8
Email: usw.firlr@pac.bluecross.ca
Phone: (604) 419-2476 Toll Free: 1-855-899-2409