TEAMSTERS' NATIONAL BENEFIT PLAN (the "Plan") MEN

MEMBER DATA FORM

Our office has received an Authorization Form from your Employer enrolling you on the Plan. In order to set up your record in our system, we require the following information:

	Last name	First		Middle	M. or F.	
Mailing Address	Street		Cit	ty	Province Postal Code	
Residential Address (if different from Mailing A		Street	Cit	 'y	Province Postal Code	
Home Phone		. Cell Phone				
	/ - Month - Yea		Insurance I	Number		
Employment Status:		Regular Employ	/ee □	Owner-Operator (Depe	endent Contractor)	
Employer:						
Have you been cove	red under this	Plan in the las	t 30 days?	Yes □ No	. 🗆	
If yes, name of Previ	ous Employei					
Dependents - Fligib	le Dependents: `	Your Spouse or con	nmon-law Spor	ise with whom you reside. Yo	ur or your Spouse's unmarried	child
under the age of 21 provid	ed the child relies	principally upon yo	ou for support a	and resides with you.	ar or your opouse s armarried	- Cillia
Please list all depe	ndents for wi	nom coverage	is to be pro	ovided.		
Name of Dependent			Sex	Date of Birth	Relationship	
			(M or F)	(Day - Month -Year)		
Last Name / First	Name / Mid	dle Name	(M Or F)	(Day - Month -Year)		
Last Name / First Last Name / First I		dle Name	(M Or F)			
Last Name / First I	 Name / Mido		(M Or F)			
Last Name / First I	 Name / Mido	lle Name	(M Or F)			
Last Name / First I Last Name / First Last Name / First Important Note: Dependent	Name / Midd Name / Midd Name / Midd children may be coge 25) provided the	dle Name dle Name le Name overed until the end o	of the month in wendance at a rec	which they turn 21 years of age. Topognized school or university and	They may continue to be eligible be direlies principally upon you for su	

Beneficiary Designation

For Group Life Insurance and Accidental Death Insurance

I hereby revoke any previous beneficiary designations made by me in respect of any benefits payable upon my death unde the provisions of the Teamsters' National Benefit Plan (and any group insurance contract the Trustees may select from time
to time to underwrite these benefits). I hereby designate the following beneficiary under the Teamsters' National Benefit Plan (and any group insurance contract the Trustees may select from time to time to underwrite these benefits) to receive any
benefits payable upon my death, and I reserve the right to change this designation at a later date.
Name of Beneficiary (Please print clearly) Relationship to you Beneficiary's date of birth
Contact Information (Telephone Number/Address)
(If you wish to appoint more than one beneficiary, please attach additional sheet (signed and dated) with detailed information.)
If beneficiary listed above is <u>under age 18 or lacks legal capacity</u> , please appoint a trustee:
Name of Trustee (Please print clearly) Relationship to you Trustee's date of birth
Contact Information (Telephone Number/Address)
If more than one beneficiary is named, settlement will be made in equal shares to the beneficiary or beneficiaries that survive the insured, unless otherwise provided by the Plan's terms, the group insurance contract or as required by law. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured.
I certify I am a Teamsters Local Union No. 31 Member.
I also certify that the persons listed as Dependents on this form are Dependents as defined by the Teamsters National Benefit Plan (the "Plan"). I authorize the Teamsters' National Benefit Plan (the "Plan") to collect, use and disclose my personal information to administer claims for benefits from the Plan and specifically to exchange my personal information with any insurance company or other organization if that exchange is reasonably necessary to administer claims. I release and hold harmless the Plan (and its employees) from any liability resulting from such collection, use or disclosure.
I understand that benefits are determined by the Board of Trustees in accordance with the Plan Text and the Agreement and Declaration of Trust. A photocopy of this authorization is as valid as the original.
DATED (Day - Month - Year) MEMBER SIGNATURE
Signature of Witness Name of Witness
Address of Witness

This form should be completed and returned to your Employer for submission to the Plan or it can be returned directly to the Plan. If you have any questions regarding completion of this form, please contact:

Teamsters' National Benefit Plan

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Email: benefits.pensions@teamstersbenefits.ca