TEAMSTERS' NATIONAL BENEFIT PLAN (the "Plan") MEMBER DATA FORM

Our office has received an Authorization Form from your Employer to enroll you in the Plan. In order to establish your record in our system, please complete this form and return it with a copy of your photo ID (i.e., Driver's License, BCID and/or Passport).

Name of Employee …… Sex……
(Please print) Last name First Middle M. or F.

Mailing Address…… …… …… ……
Street City Province Postal Code

Residential Address…… …… …… ……
(if different from Mailing Address) Street City Province Postal Code

Home Phone…… Cell Phone……

Date of Birth …… Social Insurance Number……
Day - Month - Year

Employment Status: ❑ Regular Employee ❑ Owner-Operator (Dependent Contractor)

Employer: ……

Have you been covered under this Plan in the last 30 days? Yes ❑ No ❑

If yes, name of Previous Employer……

Dependents - Eligible Dependents: Your Spouse or common-law Spouse with *whom you reside.* Your or your Spouse's unmarried child under the age of 21 provided the child relies principally upon you for support *and resides with you.*

Please list all dependents for whom coverage is to be provided.

Name of Dependent	Sex (M or F)	Date of Birth (Day - Month -Year)	Relationship
……	……	……	……
Last Name / First Name / Middle Name			
……	……	……	……
Last Name / First Name / Middle Name			
……	……	……	……
Last Name / First Name / Middle Name			
……	……	……	……
Last Name / First Name / Middle Name			

Important Note: Dependent children may be covered until the end of the month in which they turn 21 years of age. They may continue to be eligible beyond that date (but not beyond age 25) provided they are in full time attendance at a recognized school or university and relies principally upon you for support and normally resides with you. If this is the case, please contact our office for the appropriate forms.

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 under 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 under age 18 or lacks legal capacity, 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
1610 Kebet Way, Port Coquitlam, B. C. V3C 5W9
Phone 604-552-2650 Fax 604-552-2653 Toll Free 1-888-478-8111
Email: benefits.pensions@teamstersbenefits.ca
PDF Format Only - Accepted by Email

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