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

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..... Email.....

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

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

Teamster Local 31 Member Yes ❑ No ❑ Employer: .....

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

If yes, name of Previous Employer.....

Dependents

Please list all Dependents for whom coverage is to be provided. If BC Medical Services Plan (MSP) coverage is to be included, circle "Yes" and complete the attached MSP application form.

Name of Dependent	Sex (M or F)	Date of Birth (Day - Month -Year)	Relationship	MSP Include MSP?
..... Last Name / First Name / Middle Name	.....	.....	.....	Yes No
..... Last Name / First Name / Middle Name	.....	.....	.....	Yes No
..... Last Name / First Name / Middle Name	.....	.....	.....	Yes No
..... Last Name / First Name / Middle Name	.....	.....	.....	Yes No

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.

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.

Coverage may also be provided for Dependent children of any age who are mentally or physically handicapped to the extent that they are incapable of self-support. Satisfactory medical information is required.

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 <u>under age 19 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 that the persons listed as dependents on this form are Dependents as defined by the Teamsters' National Benefit Plan (the Plan). I further certify that all information provided on this form is true and correct to the best of my knowledge. I authorize the Plan to use the above information for record keeping purposes and for the administration of the Plan. In addition, I authorize that my Social Insurance Number may be used as my personal identification number for claims information and contributions for me and all other purposes of the Teamsters' National Benefit Plan. I further understand and agree that any and all information provided to the Plan may be used or disclosed by the Plan to agents of the Plan as necessary for the administration of the Plan and/or to determine eligibility for benefits. 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**.....

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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