

**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 ..... Gender.....  
(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 In accordance with T4A taxable benefit reporting to Canada Revenue Agency

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	Gender (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.)

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**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 consent to receiving any information in respect of such deposits including statements, electronically, (instead of paper copies) at the email address provided on this form (or such other email address as I may later provide to the Plan). 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**.....

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](mailto:benefits.pensions@teamstersbenefits.ca)  
*PDF Format Only - Accepted by Email*