

Teamsters' National Benefit Plan (the Plan)

1610 Kebet Way, Port Coquitlam BC V3C 5W9
 Phone: 604.552.2650 Toll-Free: 1.888.478.8111 Fax: 604.552.2653
 Email: benefits.pensions@teamstersbenefits.ca

APPLICATION FOR ENROLMENT AND BENEFICIARY DESIGNATION

The Plan office has received an Authorization Form from your employer to enroll you in the Plan. To establish your record, please complete this 2-sided form and return it to the Plan office along with a copy of any government issued photo ID. Your welcome package will be sent to you upon receipt of this form.

EMPLOYEE DATA				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH day month year		GENDER (please check) <input type="checkbox"/> Male <input type="checkbox"/> Female		SOCIAL INSURANCE # _____ - _____ - _____
MAILING STREET ADDRESS		APT #	CITY	PROVINCE POSTAL CODE
RESIDENTIAL ADDRESS IF DIFFERENT				
DAYTIME TEL # (____) ____ - ____ Home / Cell	ALTERNATE TEL # (____) ____ - ____ Home / Cell	EMAIL ADDRESS		
EMPLOYMENT STATUS				
EMPLOYER		REGULAR EMPLOYEE or OWNER-OPERATOR _____		
Have you been covered under the Plan in the past 30 days? _____ (yes) _____ (no) If yes, please provide the name of previous employer? _____				
ELIGIBLE DEPENDENTS: * Your spouse or common-law spouse who resides with you. * Children under the age of 21 who are your biological children. * Children of common law spouse under the age of 21 provided the child relies principally on you for support and resides with you.				
DEPENDENTS – please list all eligible dependents				
LAST NAME	FIRST NAME	GENDER (M / F)	DATE OF BIRTH dd/mm/yy	RELATIONSHIP TO YOU (spouse or child)

IMPORTANT NOTE: Dependent children may be covered until the end of the month at which they turn 21 years of age. They may continue to be eligible beyond that until the maximum age of 25 provided they are in full-time studies. Please contact the Plan office for further information.

BENEFICIARY DESIGNATION – FOR GROUP LIFE 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)

LAST NAME	FIRST NAME	RELATIONSHIP TO YOU	DATE OF BIRTH (dd/mm/yy)
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CONTACT INFORMATION (address / phone #)

If you wish to appoint more than one beneficiary, please provide detailed information on a separate page. Please sign and date. 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.

***IF THE ABOVE-NOTED BENEFICIARY IS UNDER THE AGE OF 18, OR LACKS LEGAL CAPACITY,
PLEASE APPOINT A TRUSTEE.*****NAME OF TRUSTEE (please print clearly)**

LAST NAME	FIRST NAME	RELATIONSHIP TO YOU	DATE OF BIRTH (dd/mm/yy)
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CONTACT INFORMATION (address / phone #)

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 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 electronic statements (in lieu of hard copies) to the email address provided on this form (or any other email address I may later provide to the Plan). I release and hold harmless the Plan (and its employees) from any liability resulting from such collections, use, or disclosure.

I understand the benefits are determined by the Board of Trustees in accordance with the Plan Text and the Agreement and Declaration of Trust. A copy of this authorization is as valid as the original.

DATED _____
(dd/mm/yy)

EMPLOYEE SIGNATURE _____

A computer-generated signature is not acceptable – please sign by hand.

Please return this completed form to the Plan office. If you require assistance, please contact:

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