IUPAT LOCAL 177 WELFARE TRUST FUND

REGISTRATION/CHANGE FORM

☐ New Application ☐ Update

Please Note: **This Registration Form is a legal document and replaces all previous Registration Forms.**

Complete all sections and sign. In order to enroll in the Plan, you must complete this Registration Form and send it to FAS (the address is at the bottom of the second page). Report any changes to your personal information by completing this form and selecting 'Update'.

1. MEMBER INFORMATION

YOU AND YOUR DEPENDENTS MUST BE INSURED UNDER YOUR PROVINCIAL HEALTH PLAN IN ORDER TO PARTICIPATE IN THIS GROUP INSURANCE PLAN.

DO YOU HAVE PROVINCIAL HEALTH COVERAGE? ☐ YES ☐ NO DO YOUR DEPENDENTS HAVE PROVINCIAL HEALTH COVERAGE ☐ YES ☐ NO

GROUP NUMBER	LOCAL UNION NUMBER:	CERTIFICATE/SOCIAL INSURANCE NUMBER
5801		

LAST NAME	FIRST NAME

GENDER	LANGUAGE	MARITAL STATUS	DATE OF BIRTH
☐ Male ☐ Female	☐ English ☐ French	☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widow ☐ Separated	(MM/DD/YY)

ADDRESS	PHONE NUMBER

CITY	PROVINCE	POSTAL CODE	EMAIL ADDRESS

2. SPOUSE'S INFORMATION

☐ *spouse or* *REQUIRED - Date of Marriage:*

☐ *Address Same As Member's Address* *Indicate if:* ☐ *common-law spouse* *If common-law, you must complete the Declaration below.*

LAST NAME	FIRST NAME	DATE OF BIRTH (MM/DD/YY)

ADDRESS	GENDER
	☐ Male ☐ Female

CITY	PROVINCE	POSTAL CODE	PHONE

DECLARATION OF COMMON-LAW SPOUSE

I _____ , do solemnly declare that I consider _____ to be my common-law spouse and our relationship as such commenced on the _____ day of_____, 20_____, and has continued to the present time. I make this declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if made under oath.

_____

Member's Signature

3. COORDINATION OF BENEFITS

Is your spouse covered under any other health and/or dental plan? ○ YES ○ NO

If yes, name of other Insurer _____

Canadian Life and Health Insurance Association (CLHIA) regulations state: A spouse first claims from his/her own plan. Children first claim under the parent with the earlier birthday. If parents are separated/divorced, children claim first under the parent with sole custody.

Benefit	Single	Family	None	Effective Date (Month/Day/Year)
Extended Health	☐	☐	☐	
Vision	☐	☐	☐	
Drug	☐	☐	☐	
Dental	☐	☐	☐	

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4. DEPENDENTS

Complete this section only when you are changing information pertaining to dependents that have previously been enrolled OR when you are adding/deleting a dependent.

Change Code * (See Below)	Date of Change ** (See Below)	Last Name	First Name	Gender M/F	Date of Birth	Relationship Code (See Below)	Request for Over-Age Coverage Attached? (see note below)	Request for Disabled Dependent Coverage Attached? (see note below)
-	(MM/DD/YYYY)				(MM/DD/YYYY)			
-	(MM/DD/YYYY)				(MM/DD/YYYY)			
-	(MM/DD/YYYY)				(MM/DD/YYYY)			
-	(MM/DD/YYYY)			M/F	(MM/DD/YYYY)		Y/N	Y/N

*** Change Type Codes**: **A** = Add, **C** = Change, **D** = Delete

Relationship Codes: **H** = Husband, **W** = Wife, **CL** = Common-Law Spouse, **S** = Son, **D** = Daughter, **SC** = Stepchild, **GC** = Grandchild, **CC** = Common-Law Child

** For eligible children, state date the child became a dependent if other than date of birth. Please note that dependent children are covered for health and dental benefits until their 18th birthday. You can continue coverage for your over-age dependent children until their 25th birthday if they are a full-time student or indefinitely if they are permanently disabled and incapable of financial self-support. **You must complete the Request for Over-Age Dependent Coverage form**. This form must be resubmitted each school term.

DEPENDENT CHILD COVERAGE

Coverage through anyone other than yourself or your current spouse

Is your dependent child covered under any other health and/or dental plan? YES NO

If you answered "**Yes**", please provide details about Insured person's health and dental insurance below.

Name of other Insured person providing coverage: _____

Date of birth of Insured person: _____

Effective Date of Coverage: _____

Relationship to dependent: _____

Which parent/guardian do dependents live with: _____

BENEFIT	COVERAGE
Extended Health	☐
Vision	☐
Drugs	☐
Dental	☐

5. BENEFICIARY FOR LIFE INSURANCE

NAME (LAST, FIRST)	RELATIONSHIP	% SHARE	DATE OF BIRTH
			(MM/DD/YY)
			(MM/DD/YY)
			(MM/DD/YY)

- FAS will retain the original beneficiary nomination and all future beneficiary designations. The legal beneficiary is the named beneficiary on file with FAS.
- You may wish to consult a legal advisor before designating a beneficiary.
- If no beneficiary is designated, the beneficiary will be your estate.
- If you wish the life insurance proceeds to be divided among two or more beneficiaries, name all of them and indicate their percentage shares, which must total 100%. If one named beneficiary predeceases you, his/her percentage share will be paid to the other beneficiaries pro rata, unless you indicate otherwise.
- If beneficiary is under 18 years of age, please complete Declaration Appointing Trustee.

For Quebec residents only: if you designated your spouse, the designation is irrevocable unless you indicate otherwise. ☐ Revocable

DECLARATION APPOINTING TRUSTEE

For beneficiaries under 18 years of age

I do hereby appoint _____ as Trustee to receive any amount due to any beneficiary under 18 years of age and declare the receipt of such Trustee shall be a good discharge to the Insurer for the amount so paid;

And I do hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such minor.

Dated at _____ _____ this _____ day of _____ , 20____ .
(city, town) (province)

_____ _____

Signature of Witness **Signature of Member**

I hereby apply for the benefits for which I am or may become eligible under the group plan ("Benefit Plan") established by my employer. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible, my social insurance number is required for identification and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of my personal information or my spouse and dependents personal information, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally in order to become eligible for and remain a member of the benefit program. I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

A photocopy or electronic version of this form is not valid for recording beneficiary designations.

(MM/DD/YY)

SIGNATURE OF MEMBER DATE

Please return to:
Funds Administrative Service Inc.
10154 – 108 Street, NW, Edmonton, AB T5J 1L3
E-mail: info@fasadmin.com | Website: www.fasadmin.com
Toll free: 1-800-770-2998
Phone (780) 452-5161 Fax (780) 452-5388