TEAMSTERS LOCAL UNION NO. 155 HEALTH BENEFITS PLAN
c/o Convyta Partners
501-4445 Lougheed Highway Burnaby BC V5C 0E4
Toll Free: 1-855-832-6155 Fax: 604-433-8894
Email: teamsters155@convyta.com

Check as Applicable:
- ❑ Original Form
- ❑ Replacement Form
- ❑ Change to Dependent Information

HEALTH BENEFITS PLAN ENROLMENT FORM

Complete and file this form with the Plan Administrator at the above address to add or change your dependents and beneficiaries for the Health Benefits Plan. PRINT clearly in ink and ensure that you and a witness have signed and dated it.

1. MEMBER INFORMATON

LAST NAME	FIRST NAME	INITIAL(S)	SOCIAL INSURANCE NUMBER

ADDRESS (street number and name)	APARTMENT OR SUITE	DATE OF BIRTH (dd-mm-yyyy)

CITY	PROVINCE	POSTAL CODE	PHARMACARE EGISTRATION NO. (where applicable)

TELEPHONE NO.	EMAIL ADDRESS	GENDER ❑ M ❑ F

2. MEMBER'S DEPENDENTS – INCLUDING SPOUSE

LAST NAME	MIDDLE INITIAL	FIRST NAME	DATE OF BIRTH (dd-mm-yyyy)	GENDER	RELATIONSHIP TO YOU

3. BENEFICIARY – LIFE AND AD&D INSURANCE

LAST NAME	MIDDLE INITIAL	FIRST NAME	PERCENTAGES	RELATIONSHIP TO YOU
			%	
			%	

4. CONTINGENT BENEFICIARY – LIFE AND AD&D INSURANCE

LAST NAME	MIDDLE INITIAL	FIRST NAME	PERCENTAGES	RELATIONSHIP TO YOU
			%	
			%	

5. APPOINTMENT OF TRUSTEE FOR A MINOR BENEFICIARY
(complete this section if you wish to appoint a trustee for a minor beneficiary)

Any amount payable to a minor beneficiary (under age 19) during his/her minority will be paid to the following individual, as Trustee for the minor child. If we cannot pay to the Trustee identified or you fail to name a Trustee, the Plan will pay the benefits to the Public Guardian and Trustees' Office.

LAST NAME	MIDDLE INITIAL	FIRST NAME	RELATIONSHIP TO YOU	CONTACT INFORMATION

Payment to the Trustee or Public Guardian shall discharge the Teamsters Local Union No. 155 Health Benefits Plan, which is not responsible for the effect of the sufficiency of appointment.

6. SIGNATURE OF MEMBER

(a) I certify that the information provided on this Form is correct and can be relied upon by the Plan.
(b) I agree to promptly update the Plan Administrator of any changes to my marital status or the dependents/beneficiaries to be designated.
(c) I agree that I am liable for benefits paid out incorrectly due to the Form including my failure to update my marital status.
(d) I agree to the collection, use and disclosure of my personal information as is reasonably required to administer my entitlements and obligations under the Plan.
(e) If I am entitled to receive documents or information from the Plan I consent to receiving electronic copies of those documents.
(f) I consent to the use of my Social Insurance Number for record keeping, tax reporting and claims purposes.

Signature of Member **X**	Date (dd-mm-yyyy)

Signature of Witness (cannot be Spouse, Dependent or Beneficiary) **X**	Name of Witness

PRIVACY STATEMENT: The Trustees of the Health Benefits Plan will collect, use and disclose personal information (including Social Insurance Number) if reasonably necessary to effectively administer the Health Benefits Plan. Personal information will be protected pursuant to the relevant privacy legislation. The Trustees may use and exchange information with relevant persons or organizations (union, health professionals, financial institutions, insurers, re-insurers, regulators, investigative agencies) in order to manage the Plan and your entitlement under the Plan. Questions related to the Privacy Policy of the Funds and Plans should be directed to the Administrator.

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CONFIRMATION OF
CANADIAN PROVINCIAL OR TERRITORIAL HEALTH PLAN COVERAGE

1. Provincial Health Coverage Confirmation

Extended Health Care (EHC) benefits are only available if you are covered under a Canadian provincial or territorial health plan (e.g., MSP in British Columbia, OHIP in Ontario, etc.).

☐ **Yes – I am covered under a Canadian provincial/territorial health plan**
☐ **No – I do not have coverage under a Canadian provincial/territorial health plan**

If you select "No," you will not be eligible for Extended Health Care benefits. Coverage will be cancelled and you will be notified.

Signature of Member **X**	Date (dd-mm-yyyy)
Signature of Witness (cannot be Spouse, Dependent or Beneficiary) **X**	Name of Witness