OPERATING ENGINEERS LOCAL 955 HEALTH & WELFARE TRUST FUND

Group Insurance Registration and Declaration of Beneficiary

FOR OFFICE USE ONLY	
Covered Date:	____________
Re-Covered:	____________
Re-Covered:	____________

Please complete this registration form in ink.

Please complete and sign all applicable sections (front and back).

Please note that no reimbursement will be paid for claims until the Registration Form is received by the Fund Office.

Member Information

Name (Last)	(First)	Social Insurance Number

Address (Street)	Marital Status	Sex (Please Circle)	Date of Birth
	☐ Single ☐ Divorced ☐ Common-Law ☐ Married ☐ Separated	M F	D M Y

City	Province	Postal Code	Telephone Number
		-	- -

Spouse's Information

Indicate if spouse ■ or common-law spouse ■ If common-law, please complete Declaration on Reverse.

Name (Last)	(First)	Social Insurance Number

Address (Street)	Marital Status	Sex (Please Circle)	Date of Birth
	☐ Single ☐ Divorced ☐ Common-Law ☐ Married ☐ Separated	M F	D M Y

City	Province	Postal Code	Spouse's Employer
		-	

Spouse's Coverage

✔	PLEASE CHECK ONE OF THE FOLLOWING:	BENEFIT	YES/NO (Please Circle)	SINGLE/ FAMILY (Please Circle)	EFFECTIVE DATE (Day/Month/Year)
	My Spouse has coverage for group benefits. (If Spouse has group benefits, please complete the section to the right in full.)	Drug	Y N	S F	
		Dental	Y N	S F	
		Vision	Y N	S F	
	My Spouse does not have coverage	Major Medical	Y N	S F	
		Do not include Alberta Health Care Coverages. Please complete ALL sections.			

Beneficiary for Life & Accident Insurance

Name

Relationship

Address

Contingent Beneficiary (Back Up/Alternate):

Name

Relationship

Address

If beneficiary is under 18 years of age, please complete Declaration Appointing Trustee.

DECLARATION APPOINTING TRUSTEE

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;

(Address) (Telephone Number)

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

Dated at ________ (City) this ______ day of ________ 20______.

(Signature of Witness) (Signature of Insured)

CEP SCEP UNION LABEL GRAPHICAL 38-C

COMPLETE REVERSE SIDE AS WELL

Dependent Information (Dependents to be covered other than spouse.)

Name (Last)	(First)	Relationship	Date of Birth D / M / Y
Name (Last)	(First)	Relationship	Date of Birth D / M / Y
Name (Last)	(First)	Relationship	Date of Birth D / M / Y
Name (Last)	(First)	Relationship	Date of Birth D / M / Y
Name (Last)	(First)	Relationship	Date of Birth D / M / Y

If children have a different last name than yours, please attach their AHC statement or if from another province we require a copy of their Birth Certificate indicating parentage.

If your dependents have coverage through anyone other than yourself or your current spouse, please complete the following:

Name of Insured Person Providing Coverage: ______________________

Relationship to dependent: ______________ Date of Birth of Insured Person (Day/Month/Year): ______________

Employer of Insured Person: ______________________

Declaration of Common-law Spouse (Please complete if your common-law spouse has not been registered with the Fund office.)

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 also declare that neither my common-law spouse nor myself are married to any other person or in the event that we were prohibited from marrying by reason of a previous marriage that we were publicly represented as man or wife for a period of at least 1 year. 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.

Participant's Signature: ______________________

DECLARED before me at ______________ in the Province of ______________

this ______ day of ______________, 20 ______.

____

Commissioner for Oaths for the Province of ______________

PLEASE NOTE:
This form must be SWORN & STAMPED by a Commissioner for Oaths.

Authorization and Consent to Use Social Insurance Number

I hereby authorize my employer/plan sponsor and insurance carrier to record and refer to my Social Insurance Number, as shown above, for record keeping, benefit plan administration and claims paying purposes. I further declare that the statements I have made on this form are complete and true to the best of my knowledge. I understand that if any statement is incomplete or false, any coverage granted may be void. I understand that it is my obligation to notify the Plan of any changes to my coverage or information given on this form.

While it is the member's responsibility to ensure information is updated with all IUOE 955 entities, please note that some of the information provided here, or to the Union office, MAY be used to update your Health & Welfare Trust and/or Pension Trust records.
By signing this form, you are authorizing such updates.

Signature of Member ______________________ Date ______________