UFCW LOCAL 832/WESTFAIR FOODS LTD. BENEFIT PLAN

3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

Please print clearly and complete the entire form

BEFORE SIGNING THIS FORM, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION" CONTAINED HEREIN. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE PLAN ADMINISTRATOR.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your dependants and beneficiary(ies). This information comes from this form, the reports your Employer submits to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Plan administrator, and, it is used to: communicate with you; determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; pay taxes; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the Plan administrator.

SOCIAL INSURANCE NUMBER	FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME

BENEFICIARY FOR LIFE INSURANCE

I do hereby designate and appoint the following beneficiary to receive any death benefit that may become payable under the Plan. I reserve the right to change my beneficiary from time to time, subject to complying with the applicable laws and regulations governing the designation of beneficiaries.

Last Name First Name Relationship

_____ my _____

I understand that if I do not designate a beneficiary or if my designated beneficiary predecease(s) me and no others have been appointed, the death benefit, if any, shall be payable to my estate.

If your named Beneficiary are under age 18, please appoint an adult other than yourself, to be a Trustee, to receive and disburse any Life Insurance benefits payable to them. Any payment so made to the Trustee will discharge the Plan to the extent of such payment.

I hereby appoint _____ my _____ if living, as Trustee.

AUTHORIZATION

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy the personal information noted on this form. This authorization will survive as long as this information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that if I withhold or revoke my consent to its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purpose.

Furthermore, I certify that the information, given on this form, is true, correct, and complete, to the best of my knowledge and belief.

Member Signature _____

Date _____