

# 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			
MAILING ADDRESS		CITY	PROVINCE	POSTAL CODE	PHONE NO.	
DATE OF BIRTH DAY      MO.      YEAR		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED OR <input type="checkbox"/> SINGLE            DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> COMMON LAW		GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF EMPLOYMENT DAY      MO.      YEAR	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART-TIME

## DEPENDANT INFORMATION (SEE REVERSE OF FORM FOR DEFINITION OF DEPENDANT)

LIST FIRST AND LAST NAME OF SPOUSE AND DEPENDANT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY      MO.      YEAR	LIST FIRST AND LAST NAME OF ADDITIONAL DEPENDANT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY      MO.      YEAR

Are your Dependants living with you?     Yes     No

Do any of your Dependants work for Westfair?

No       Yes – Name \_\_\_\_\_ SIN \_\_\_\_\_

Do any of your Dependants have Medical/Drug coverage under another plan?

No       Yes – Name \_\_\_\_\_ SIN \_\_\_\_\_

Insurance Company/Policy# \_\_\_\_\_

## BENEFICIARY FOR LIFE INSURANCE

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

Last Name	First Name	Relationship	Percentage % (must total 100%)
_____	_____	my _____	_____
_____	_____	my _____	_____
_____	_____	my _____	_____

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

**If any of your named Beneficiaries 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.

**PLEASE TURN OVER**

## DEFINITION OF DEPENDANT

“SPOUSE” means a person who is:

- (a) legally married to you and is living with you, or
- (b) living with you in a common-law relationship, or a person of the same gender with whom you have lived in a marriage like relationship, in either case for at least one continuous year if neither of you is married or 3 years if one of you is legally married.

At any one time, only the person designated on this form will be considered to be your Spouse.

“DEPENDANT CHILD” means your unemployed, unmarried natural, or legally adopted child, step child, or the child of your common-law or same gender Spouse, who lives with you or is in residence at a recognized educational institution and who is: (a) under 18 years of age; or

- (b) 18 years of age or older but less than 25 years of age and is attending a recognized educational institution full time; or
- (c) 18 years of age or older and is not capable of self-sustaining employment by reason of mental or physical disability which commenced prior to the child’s 18th birthday.

A child of a common-law or same gender Spouse must have lived with you for a minimum of 12 consecutive months.

**Your common-law or same gender Spouse and the children or your common-law or same gender Spouse must be listed on this form. If acquired later, they must be listed on the Administrator’s records for at least 12 months in order to be considered your Dependant.**

## 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 \_\_\_\_\_ Spouse Signature \_\_\_\_\_

Signature of Dependant Child Age 18 or Over \_\_\_\_\_

Signature of Dependant Child Age 18 or Over \_\_\_\_\_

Date \_\_\_\_\_