LABOURERS' LOCAL 1089 (SARNIA) BENEFIT TRUST
MEMBER INFORMATION CARD

Complete all details requested (please print) and mail to the PLAN ADMINISTRATOR:

Labourers' Local 1089 (Sarnia) Benefit Trust Fund
1255 Confederation Street
Sarnia, Ontario N7S 4M7

Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Social Insurance Number: _____ Policy Number: _____ Member Number: _____

Members' Name: _____
last name first middle

Members' Address: _____
Street / Number City Province Postal Code

Members' Birth Date: _____ Phone: _____
day month year

~~Division:~~ _____ ~~Benefit Class:~~ _____ ~~Earnings:~~ _____ ~~Eligibility Date:~~ _____
day month year

Insured Dependents

This section is to be completed by the plan member.

Please print clearly, in INK.

Do you have a spouse (married, common-law or civil union spouse)? _____ Yes _____ No

Do you have dependant children, including full time students or disabled adults? _____ Yes _____ No

How many dependants in total, including spouse? _____

Spouse (full name)	Date of Birth (day/month/year)	Date of marriage (day/month/year)	
Children (full name)	**Date of Birth (day/month/year)**	**Children (full name)**	**Date of Birth (day/month/year)**
○ Male ○ Female		☐ Male ☐ Female	
○ Male ○ Female		☐ Male ☐ Female	
○ Male ○ Female		☐ Male ☐ Female	

Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original of this form will be required for a life claim.

Crossed out beneficiary designations must be initialled.

Please print clearly, in INK.

Beneficiary Designation

Beneficiary's name(s)			Percent allocated	Relationship to plan member
last name	first name	middle initial		
last name	first name	middle initial		
last name	first name	middle initial		

To be divided as per the percentages indicated above, or in equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to Great-West Life. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the circle marked "Revocable", below.

I hereby make the above beneficiary designation:

○ **Revocable**, I may change this beneficiary designation at any time.

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

Privacy

This section explains Great-West Life's commitment to privacy.

Protecting Your Personal Information

As your insurers, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in our offices or the offices of an organization authorized by us. We limit access to personal information in your file to the insurers staff or persons authorized by our organizations who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

CONTINUE ON REVERSE SIDE

Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

Authorizations and Declarations

I hereby apply for coverage under the group benefits plan issued by your insurers. I authorize:

- my plan sponsor to deduct from my pay and remit to the insurers the plan member contributions required under the plan, if applicable;
- the insurers to use my social insurance number for tax reporting purposes and as an identification number where it is required in the administration of the plan;
- the insurers, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with my insurers to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations and Declarations section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature: _____ **Date:** _____

Contingent Beneficiary Designation

Beneficiary's name(s)			Percentage allocation	Relationship to plan member
_____			_____	_____
Last name	first name	middle initial		
_____			_____	_____
Last name	first name	middle initial		
_____			_____	_____
Last name	first name	middle initial		