

CARPENTERS' RESIDENTIAL TRUST FUNDS

MEMBER INFORMATION CARD

- Please Check One:**
- D New Member Card
 - D Replacement Card
 - D Change in Address
 - D Change in Member's Name
 - D Change in Beneficiary
 - D Change in Marital Status
 - D Change in Dependants

SOCIAL INSURANCE NUMBER:

PLAN:

(to be completed by union)

LAST NAME	FIRST/ MIDDLE NAME(S)	(AREA CODE) TELEPHONE NUMBER
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STREET NUMBER/ NAME	APT. NO.	CITY	PROVINCE	POSTAL CODE
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DATE OF BIRTH	UNION INITIATION DATE	MARITAL STATUS	<input type="radio"/> SINGLE <input type="radio"/> COMMON-LAW <input type="radio"/> DIVORCED	<input type="radio"/> MARRIED <input type="radio"/> SEPARATED <input type="radio"/> WIDOWED
MO. DAY YEAR	MO. DAY YEAR			
		If Common-law, indicate date co-habitation began _____		
		mm / dd / yyyy		

DEPENDANT INFORMATION (Spouse & Children)

LAST NAME	FIRST/ MIDDLE NAME(S)	DATE OF BIRTH			SEX	RELATIONSHIP TO MEMBER
		MO.	DAY	YEAR		

Please complete BOTH sides of this Card and return to the Plan Administration Office: 45 McIntosh Drive, Markham, Ontario L3R 8C7

**BENEFICIARY INFORMATION – CARPENTERS’ RESIDENTIAL HEALTH AND WELLNESS FUND AND
CARPENTERS’ LOCAL 1030 VACATION PAY TRUST FUND**

LAST NAME	FIRST / MIDDLE NAME(S)	RELATIONSHIP TO MEMBER			
STREET NUMBER / NAME		APT. NO.	CITY	PROVINCE	POSTAL CODE

BENEFICIARY INFORMATION – CARPENTERS’ LOCAL 1030 PENSION TRUST FUND

LAST NAME	FIRST / MIDDLE NAME(S)	RELATIONSHIP TO MEMBER			
STREET NUMBER / NAME		APT. NO.	CITY	PROVINCE	POSTAL CODE

Caution: Designation of a Beneficiary by way of this Member Information Card will not be revoked or automatically changed by any future marriage or divorce. If you wish to change your Beneficiary for any reason, including marriage or divorce, you must complete and submit a new Member Information Card to the Plan Administration Office. Please refer to your Member Information Booklet for more information about designating a Beneficiary.

If you designate a Beneficiary who is a minor under the Age of Majority, it is recommended you complete the Trustee Appointment below.

TRUSTEE APPOINTMENT CLAUSE (For Under Age Beneficiaries)

I hereby nominate and appoint the Trustee named below to receive and disperse any monies payable under these Plans to my Designated Beneficiary(ies) during their minority. Any monies paid to this Trustee will release the Insurer and Plan Administrator of any further liability.

TRUSTEE’S LAST NAME	TRUSTEE’S FIRST / MIDDLE NAME(S)	TRUSTEE’S RELATIONSHIP TO MEMBER
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Privacy Policy Statement: The Plans collect, maintain and communicate personal information (including Social Insurance Number) necessary for the administration of the Plans. Personal information is protected pursuant to applicable legislation. The Plans may use and exchange personal information with relevant organizations (unions, health professionals, financial institutions, investigative agencies, regulators, legal counsel, etc.) to manage the Plans and your entitlement to the Benefits of the Plans. Please direct any questions related to the Privacy Policy of the Plans to the Plan Administration Office.

I understand that I have the right to change my Beneficiary(ies) at any time by written notice to the Plan Administration Office, subject to the provisions of any applicable law or regulation. I further understand if my designated Beneficiary(ies) should predecease me and no other Beneficiary has been appointed thereafter, any proceeds from these Plans shall be payable to my estate subject to applicable legislation. The information on this Member Information Card is true and complete.

Member’s Signature: _____ **Date:** _____

Witness to Member’s Signature: _____ **Witness’ Name:** _____