



**CARPENTERS' RESIDENTIAL BENEFIT PLANS  
MEMBER INFORMATION FORM**

**IMPORTANT NOTE:** Please fill out this form completely. The information provided on this form will replace information provided on all earlier Member Information Forms or Application Cards. You must notify us of any changes to the information below.

**MEMBER'S PERSONAL INFORMATION**

NAME: LAST		FIRST / MIDDLE			SOCIAL INSURANCE NUMBER					
APT. NO.	NUMBER / STREET			CITY		PROVINCE		POSTAL CODE		
EMAIL				TELEPHONE			MALE <input type="checkbox"/>		FEMALE <input type="checkbox"/>	
		NON-BINARY <input type="checkbox"/>								
DATE OF BIRTH			DIVISION NAME		UNION INITIATION DATE			MARITAL STATUS		
MONTH	DAY	YEAR	<input type="checkbox"/> SHINGLING	<input type="checkbox"/> FLOORING	MONTH	DAY	YEAR	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
			<input type="checkbox"/> EAVESTROUGHING	<input type="checkbox"/> SIDING				<input type="checkbox"/> Common-Law	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced
			<input type="checkbox"/> CAULKING							

**LOCAL**      \_\_\_ Local 27      \_\_\_ Local 1030

**MARITAL STATUS**

If you are married, please provide date of marriage: \_\_\_\_\_

If you are Separated or Divorced, please provide a copy of your Divorce/Separation Agreement.

If you are in a Common-Law relationship, please complete the following statement:

I do hereby declare that \_\_\_\_\_ (spouse's name - please print) is my Common-Law Spouse with whom I have been cohabiting since \_\_\_\_\_ (date cohabitation commenced) and whom I publicly represent as my Spouse.

\_\_\_\_\_ (Your Signature)

**PERSONAL INFORMATION ABOUT MEMBER'S DEPENDANTS - INCLUDING SPOUSE**

Please list your spouse and dependant children under the age of 21, or under the age of 25 if in attendance at an accredited school. Child dependants over the age of 25 who are incapable of self-support may also be covered.

NAME: LAST	FIRST / MIDDLE	DATE OF BIRTH			SEX M/F/NB	RELATIONSHIP
		MONTH	DAY	YEAR		

The Trustees of the Plans reserve the right to request further documentation supporting the enrollment of any Dependant added for coverage under the Plans. Such supporting documentation may include a marriage certificate, birth registration or other documents supporting a common law relationship. I hereby certify that the requested information provided above is true and complete. I understand and agree that the coverage and benefits of the Plans (and future claims) may be denied, or terminated, and that the Trustees may take such other actions as they deem necessary in their sole discretion, as a result of me or my Dependants providing false, incomplete, or misleading information to the Plans. I consent to the collection of my personal information for Plan administration purposes.

**COORDINATION OF BENEFITS**

Is benefit coverage available to you and/or Dependants from another health benefit plan(s)?    **Yes**                      **No**

If Yes, please provide:  
Name of individual(s) covered as the member under the other plan(s): \_\_\_\_\_

Relationship (ie: spouse, ex-spouse, step-parent to my Dependants, guardian to my Dependants): \_\_\_\_\_

Name of other plan(s): \_\_\_\_\_

Does the other benefit plan provide coverage for your whole family, or just the individual listed?  
Family Coverage    \_\_\_                      Single Coverage    \_\_\_

**COMPLETE BOTH SIDES AND RETURN TO THE PLAN ADMINISTRATION OFFICE**

45 McIntosh Drive, Markham, Ontario L3R 8C7 www.carpentersresidential.ca

Revised June 2021

Please indicate your marital status.

**This signature is only required if member is in a Common-Law relationship.**

Please list your spouse and dependant children under the age of 21, or under the age of 25 if in attendance at an accredited school. Child dependants over the age of 25 who are incapable of self-support may also be covered.

**If you are participating in the Health and Wellness Plan, please complete this section.**

If you or your spouse/ dependants are covered under any other benefit plan, please provide the information here

Does the other benefit plan provide coverage for your whole family, or just the individual listed?

**CARPENTERS' RESIDENTIAL BENEFIT PLANS - MEMBER INFORMATION FORM**

**CARPENTERS' RESIDENTIAL HEALTH AND WELLNESS FUND BENEFICIARY**

*Group Term Life Insurance and Accidental Death and Dismemberment*

LAST NAME	FIRST/MIDDLE	RELATIONSHIP
TELEPHONE	EMAIL	

Check this box if the above named is an irrevocable beneficiary

If the above beneficiary(ies) predeceases me, my contingent beneficiary is: \_\_\_\_\_  
First name, Last name Relationship

If your original and contingent beneficiary predeceases you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

**CARPENTERS AND ALLIED WORKERS LOCAL 27 SHINGLING & SIDING DIVISION PRODUCTIVITY BONUS TRUST FUND OR CARPENTERS' LOCAL 1030 VACATION PAY TRUST FUND BENEFICIARY**

LAST NAME	FIRST/MIDDLE	RELATIONSHIP
TELEPHONE	EMAIL	

Check this box if the above named is an irrevocable beneficiary

If the above beneficiary(ies) predeceases me, my contingent beneficiary is: \_\_\_\_\_  
First name, Last name Relationship

If your original and contingent beneficiary predeceases you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

**CARPENTERS' RESIDENTIAL GROUP RRSP TRUST FUND BENEFICIARY - FILED USING A SEPARATE DOCUMENT WITH THE RRSP PLAN CUSTODIAN.**

**CARPENTERS' RESIDENTIAL PENSION TRUST FUND BENEFICIARY**

LAST NAME	FIRST/MIDDLE	RELATIONSHIP
TELEPHONE	EMAIL	

Check this box if the above named is an irrevocable beneficiary

If the above beneficiary(ies) predeceases me, my contingent beneficiary is: \_\_\_\_\_  
First name, Last name Relationship

If your original and contingent beneficiary predeceases you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

Caution: Your designation of a beneficiary by means of this Member Information Form will not be revoked or changed automatically by any future event (including marriage or divorce) unless required by law or regulation. Should you wish to change your beneficiary, you must do so by completing a new Member Information Form.

**TRUSTEE FOR ALL FUNDS**

Trustee's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
first name, last name

By signing below, I hereby certify that the information provided is true to the best of my knowledge, and consent to the collection, maintenance, use and disclosure of my personal information as described in the Privacy Statement below. I acknowledge that providing my consent will allow access to the information required to assess my benefit eligibility and entitlement, and that refusing to consent may result in delay or denial of my request and/or benefit. This consent may be revoked by me at any time by sending written instructions to the Plan Administration Office.

**I consent to the collection, use and disclosure of my personal information**  YES  NO

**Signature and Consent** \_\_\_\_\_

**Date** \_\_\_\_\_

**Please ensure that your signature is witnessed by someone other than your Spouse or Beneficiary.**

**Witness Signature:** \_\_\_\_\_ **Witness Printed Name:** \_\_\_\_\_

**Witness Telephone:** \_\_\_\_\_ **Witness address:** \_\_\_\_\_

**Witness Email:** \_\_\_\_\_

**Privacy Statement:** I authorize the Carpenters' Residential Benefit Plans (called "the Plan"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plan or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plan. Personal information will be protected pursuant to the applicable legislation. The Plan may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plan and entitlement to the benefits of the Plan, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.

**COMPLETE BOTH SIDES AND RETURN TO THE PLAN ADMINISTRATION OFFICE**

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Revised June 2021

**If you are participating in the Health and Wellness Fund, please complete this section.**

The person(s) named as your Health and Wellness Beneficiary will be the recipient of your life insurance payment (if applicable).

**If you are participating in the Productivity Bonus or Vacation Pay Trust Fund, please complete this section.**

The person(s) named as your Productivity Bonus or Vacation Pay beneficiary will be the recipient of any remaining Productivity Bonus benefit Upon your death

**If you are participating in the Pension Trust Fund, please complete this section.**

The person(s) named as your Pension Trust Fund Beneficiary will be the recipient of any remaining pension benefits (if applicable).

**Irrevocable beneficiaries can't be removed from the policy without their consent.**

The person named as a Trustee will receive any benefits payable on behalf of your beneficiary(ies), if they are under the age of majority at the time of your death (not applicable in Quebec).

**This form requires a witness who is not your spouse or beneficiary to sign where indicated.**