UBC BUILT
CARPENTERS' REGIONAL COUNCIL

CARPENTERS' RESIDENTIAL BENEFIT PLANS - FLOORING DIVISION ONLY
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

UNION ID NUMBER: U

NAME: LAST | FIRST / MIDDLE | SOCIAL INSURANCE NUMBER

APT. NO. | NUMBER / STREET | CITY | PROV. | POSTAL CODE

EMAIL | TELEPHONE | M-MALE ☐ F-FEMALE ☐ NB-NON-BINARY ☐

DATE OF BIRTH (MONTH / DAY / YEAR) | UNION INITIATION DATE (MONTH / DAY / YEAR)

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Common-Law ☐ Separated ☐ Divorced

MARITAL STATUS

Please indicate your 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.

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

_____ (Your Signature)

PERSONAL INFORMATION ABOUT MEMBER'S DEPENDANTS - INCLUDING SPOUSE

Please list your spouse and dependant children under the age of 22, 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.

Please list Dependants for benefit coverage below. Common-Law spouses are eligible for **benefits** if they have been living together in a conjugal relationship for 12 consecutive months.

NAME: LAST	FIRST / MIDDLE	DATE OF BIRTH MONTH	DAY	YEAR	SEX M-MALE/F-FEMALE/NB-NON-BINARY	RELATIONSHIP

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

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

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

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

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 PAGES AND RETURN TO THE PLAN ADMINISTRATION OFFICE

CARPENTERS' RESIDENTIAL BENEFIT PLANS - FLOORING DIVISION ONLY
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If you are participating in the Health and Wellness Fund, please complete this section.

CARPENTERS' RESIDENTIAL HEALTH AND WELLNESS FUND BENEFICIARY

Group Term Life Insurance and Accidental Death and Dismemberment

LAST NAME	FIRST/MIDDLE	RELATIONSHIP
TELEPHONE	**EMAIL**	

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

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 predecease you and no new beneficiaries have been appointed, benefits payable are paid to your Estate.

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

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

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).

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**

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

_____ _____
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 Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans 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 Plans and entitlement to the benefits of the Plans, 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 PAGES AND RETURN TO THE PLAN ADMINISTRATION OFFICE