LiUNA Local 1059 Benefit Trust

W.A. Health Inc. 149 Main St E, Hamilton ON L8N 1G4 • (289) 768-3621 • admin@wahealth.ca

GROUP BENEFIT ENROLMENT AND BENEFICIARY DESIGNATION FORM

Please type or print clearly. Complete all items on both sides of the form in detail. To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your Plan Administrator of any changes such as change of name, marital status, dependent status, or change of beneficiary.

Plan Member Information

Last Name _____ First Name _____ Initial _____ Social Insurance Number _____

Apt. Number/Street Number/Street Name _____ City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____ Email Address _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Member's Date of Birth _____ mm/dd/yyyy

Initiation Date _____ mm/dd/yyyy

Date of marriage or if common law date on which cohabitation period started _____ mm/dd/yyyy

Dependent Information

This section allows you to define who will be entitled to your Health and Group Legal Benefits. If you require additional fields, please complete another form and submit together.

Spouse

Last Name	First Name	D.O.B. mm/dd/yyyy	Sex	Is this individual covered by another group insurance plan?
			☐ M ☐ F	☐ Yes ☐ No

Children and Dependents

Last Name	First Name	D.O.B. mm/dd/yyyy	Sex	Is this individual covered by another group insurance plan?
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No
			☐ M ☐ F	☐ Yes ☐ No

Primary Beneficiary Designation

This section must be completed to designate a beneficiary for your life benefits and other benefits which may become payable under the Benefit Trust upon your death. If no beneficiary is named or the primary beneficiary predeceases you, the proceeds shall be paid to your estate.

I hereby revoke all previous Primary Beneficiary designations and designate the following as beneficiary(ies). The sum of all percentages must add to 100%. You may leave the % fields blank if you wish to divide the proceeds equally among all the names listed in this section.

Primary Beneficiary

Last Name _____ First Name _____ Percent Allocated _____% Relationship to Plan Member _____

Apt. Number/Street Number/Street Name _____ City _____ Province _____ Postal Code _____

Last Name _____ First Name _____ _____%

Apt. Number/Street Number/Street Name _____ City _____ Province _____ Postal Code _____

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Contingent Beneficiary Designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section. If there are no Contingent Beneficiaries at the time of my death, the proceeds shall be paid to your estate.

I hereby revoke all previous Contingent beneficiary designations and designate the following as beneficiary(ies)

Contingent Beneficiary | Percent Allocated | Relationship to Plan Member

_____ _____% _____

Last Name First Name

_____

Apt. Number/Street Number/Street Name City Province Postal Code

_____ _____% _____

Last Name First Name

_____

Apt. Number/Street Number/Street Name City Province Postal Code

Privacy

This section explains W.A. Health's commitment to privacy

At W.A. Health we recognize and respect the importance of privacy.

Your personal information:
When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us and may also include financial or health information. Your information is kept in the offices of W.A. Health or the offices of an organization authorized by W.A. Health.

Who has access to your information:
We limit access to personal information in your file to W.A. Health staff or persons authorized by W.A. Health who require it to perform their duties and to persons to who you have granted access. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your Information is used for:
Personal information that we collect will be used for the purposes of determining your eligibility for products, service or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for W.A. Health and its affiliates' internal data management and analytics purposes.

If you want to know more:
If you have questions about our personal information policies and practices, write to LiUNA Local 1059 Benefit Trust c/o W.A. Health Chief Compliance Officer at:

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Authorization and Declarations

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

I have read and understand and agree with the contents of the section on this form entitled "privacy".

I authorize:

W.A. Health, 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 W.A. Health or the above to exchange personal information, when necessary to determine eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section valid as the original.

I authorize the use of my Social Insurance Number as my Certificate Number under the group plan and as my identification number in the LiUNA Local 1059 Benefit Trust Fund database.

I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature:_____ Date:_____
mm/dd/yyyy