



LiUNA Local 1059 Benefit Trust

W.A. Health Inc. 149 Main St E, Hamilton ON L8N 1G4 Phone: (289) 768-3621

Email Form to: customerservice@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.

GROUP 2

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: <input type="checkbox"/> Male <input type="checkbox"/> Female									
Marital Status:		Single	Common Law	Married	Separated	Divorced	Widowed		
Member's Date of Birth				Initiation Date		Date of marriage or if common law date on which cohabitation period started			
mm/dd/yyyy				mm/dd/yyyy		mm/dd/yyyy			

Dependent Information Spouse

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

Primary Beneficiary Designation

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.

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.

Primary 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

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:

LiUNA Local 1059 Benefit Trust
c/o W.A. Health
149 Main St E
Hamilton, ON L8N 1G4
(289) 768-3621
customerservice@wahealth.ca

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