UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

Registration Form

3rd Floor, 880 Portage Avenue Winnipeg, Manitoba R3G 0P1

Please print clearly and complete the entire form

BEFORE SIGNING THIS FORM, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION" CONTAINED HEREIN. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE PLAN ADMINISTRATOR.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your dependants and beneficiary(ies). This information comes from this form, the reports your Employer submits to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Plan administrator, and, it is used to: communicate with you; determine coverage and benefit entitlement; satisfy any reporting requirements of the provincial and federal governments; pay taxes; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the Plan administrator.

SOCIAL INSURANCE NUMBER	FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME	
MAILING ADDRESS	**CITY**	**PROVINCE**	**POSTAL CODE**	**PHONE NO.** ( ) –
DATE OF BIRTH DAY MO. YEAR	**MARITAL STATUS** ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED OR DIVORCED ☐ COMMON LAW	**SEX** ☐ FEMALE ☐ MALE	**DATE OF EMPLOYMENT** DAY MO. YEAR	**EMPLOYMENT STATUS** ☐ FULL TIME ☐ PART TIME

Employment Location: ☐ Winnipeg ☐ Brandon ☐ Hamilton

DIRECT DEPOSIT FOR CLAIM PAYMENTS - BANKING INFORMATION

Bank Account Holder's Name (if different from Plan Member) _____

ATTACH A "VOID" CHEQUE TO THIS FORM, OR, HAVE YOUR FINANCIAL INSTITUTION COMPLETE THE FOLLOWING BANK ACCOUNT INFORMATION:

Name of Financial Institution		Address of Financial Institution
Branch (Transit) Number (5 digits)	Bank Number (3 digits)	Account Number (maximum 12 digits)

An electronic Explanation of Benefits (EOB) showing what has been paid will be emailed to you once your claim has been processed.

Email address: _____

DEPENDANT INFORMATION *(SEE REVERSE OF FORM FOR DEFINITION OF DEPENDANT)*

LIST FULL NAME OF SPOUSE AND DEPENDANT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR	LIST FULL NAME OF DEPENDANT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR

Does your Spouse have Prescription Drug coverage under another plan?

☐ No

☐ Yes (If Yes, name of Insurance Company, Policy Number and Effective Date of Coverage) _____

Is your Spouse employed by Maple Leaf Foods? ☐ No ☐ Yes – Spouse's Name _____

PLEASE TURN OVER TO COMPLETE THE BENEFICIARY DESIGNATION AND SIGNATURES OF AUTHORIZATION

BENEFICIARY FOR LIFE INSURANCE

I do hereby designate and appoint the following beneficiary(ies) to receive any death benefit that may become payable under the Plan. I reserve the right to change my beneficiary(ies) from time to time, subject to complying with the applicable laws and regulations governing the designation of beneficiaries.

Last Name	First Name		Relationship	Birth Date	Percentage %
_____	_____	my	_____	_____	_____
_____	_____	my	_____	_____	_____
_____	_____	my	_____	_____	_____

I understand that if I do not designate a beneficiary or if my designated beneficiary(ies) predecease(s) me and no others have been appointed, the death benefit, if any, shall be payable to my estate.

IF A DESIGNATED BENEFICIARY IS UNDER AGE 18 PLEASE COMPLETE THE FOLLOWING:

I hereby appoint _____ my _____ if living, as Trustee to receive and disburse any monies payable hereunder to the above named child(ren) during minority, and any payment so made to the said Trustee shall discharge the Plan to the extent of such payment.

Member Signature _____ Date _____

DEFINITION OF DEPENDENT

"SPOUSE" means a person legally married to you and living with you, or a person of the same gender with whom you have lived in a marriage-like relationship for at least one year, or a common-law spouse whom you publicly represent as your husband or wife and who has lived with you for at least one year if neither of you is married, or for 3 years if one of you is legally married.

Your common-law/same gender spouse must be listed on this form. If listed later, he/she will have to be listed on the Administrator's records for at least 12 months before becoming eligible for benefits.

"DEPENDANT CHILD" means an unmarried, natural, legally adopted child or step child, or the child of a common-law or same gender spouse, who if employed, works less than full-time hours, and who lives with you or is in residence at a recognized educational institution, and who is:

- under age 22; or
- age 22 or older but less than age 25, and attending a full-time course of education at a recognized school, college or university; or
- age 22 or older and is incapable of self-sustaining employment due to a mental or physical handicap which commenced prior to the child's 22nd birthday.

provided you or your common-law/same gender spouse contribute regularly to the support of such child.

A child of your common-law/same gender spouse is considered dependent if the child has resided with you for at least 12 consecutive months.

A child of your common-law/same gender spouse must be listed on this form. If listed later, he/she will have to be listed on the Administrator's records for at least 12 consecutive months before becoming eligible for benefits.

AUTHORIZATION

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy the personal information noted on this form. This authorization will survive as long as this information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that if I withhold or revoke my consent to its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purpose.

Furthermore, I certify that the information, given on this form, is true, correct, and complete, to the best of my knowledge and belief.

_____ _____
Signature of Member Date

_____ _____
Signature of Spouse Date

_____ _____
Signature of Dependant Child Age 18 or Over Date

_____ _____
Signature of Dependant Child Age 18 or Over Date