UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

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

Registration Form

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	SEX	DATE OF EMPLOYMENT DAY MO. YEAR	EMPLOYMENT STATUS
	☐ MARRIED ☐ SEPARATED OR DIVORCED ☐ SINGLE ☐ COMMON LAW ☐ WIDOWED	☐ FEMALE ☐ MALE		☐ FULL TIME ☐ PART TIME

Employment Location: ☐ Winnipeg ☐ Brandon ☐ Hamilton ☐ Paquin

MANDATORY DIRECT DEPOSIT FOR CLAIM PAYMENTS - BANKING INFORMATION

IMPORTANT NOTE: THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL OR YOUR CLAIMS WILL NOT BE PAID.

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 FIRST AND LAST NAME OF SPOUSE AND DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR	LIST FIRST AND LAST NAME OF ADDITIONAL DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR

Are your Dependants living with you? ☐ Yes ☐ No

Do any of your Dependants have Medical/Drug coverage under another plan?

☐ No ☐ Yes – Name of Insurance Company and Policy Number: ____________________

Do any of your Dependants also work for Maple Leaf Foods?

☐ No ☐ Yes – Name ____________________ SIN ____________________

PLEASE TURN OVER ⇨

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 % (must total 100%)
______	______	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 any of your named Beneficiaries are under age 18, please appoint an adult other than yourself, to be a Trustee, to receive and disburse any Life Insurance benefits payable to them. Any payment so made to the Trustee will discharge the Plan to the extent of such payment.

I hereby appoint ____ my ____________________________ if living, as Trustee.

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.

"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 to be a Dependant if the child has resided with you for at least 12 consecutive months.

Your common-law/same gender Spouse and the children of your common-law/same gender Spouse must be listed on this form. If not listed, or you enter into such a relationship after completing this form, they must be listed on the Administrator's records for at least 12 months in order to be considered to be your Dependant.

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.

Member Signature ____________________________ Spouse Signature ____________________________

Signature of Dependent Child Age 18 or Over ____

Signature of Dependent Child Age 18 or Over ____

Date ____________________________