MANITOBA SAFEWAY/UFCW LOCAL 832 HEALTH & WELFARE PLANS

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" ON THE REVERSE SIDE OF THIS FORM. 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	GENDER	DATE OF EMPLOYMENT DAY MO. YEAR	EMPLOYMENT STATUS
	☐ MARRIED ☐ SEPARATED OR DIVORCED ☐ SINGLE ☐ COMMON LAW ☐ WIDOWED	☐ FEMALE ☐ MALE		☐ FULL TIME ☐ PART-TIME

EMPLOYER: ☐ **SAFEWAY** ☐ **CO-OP** ☐ **BIMBO CANADA**

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

FIRST AND LAST NAME OF **SPOUSE** AND DEPENDANT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR	FIRST AND LAST NAME OF ADDITIONAL DEPENDANT 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 _____ SIN _____

Insurance Company/Policy#_____

Do any of your Dependants work at Safeway, CO-OP or Bimbo Canada?

☐ No ☐ Yes – Name _____ SIN _____

BENEFICIARY FOR LIFE INSURANCE

I do hereby designate and appoint the following persons to receive any death benefit that may become payable. 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.

PLEASE TURN OVER ⇨

DEFINITION OF DEPENDANT

"SPOUSE" means a person who is legally married to you by virtue of a religious or civil marriage, or a person who is living with you in a common-law relationship if such person is publicly represented as your husband or wife and has been living with you for a period of at least one continuous year, or a person of the same gender with whom you have lived in a marriage-like relationship for at least one year. At any one time, only the person designated on this form will be considered to be your Spouse.

Your common-law/same gender spouse must be listed on this form. If listed later, he/she will have to wait for 12 consecutive months before becoming eligible for benefits.

"DEPENDANT CHILD" means an unmarried, natural, legally adopted child or step child, who is chiefly dependent on you for financial support, or the child of your common-law Spouse or same gender Spouse, who is:

- under age 21; or
- age 21 or older but less than age 25, and attending a full curriculum of education at a recognized school, college or university; or
- age 21 or older and is not capable of self-sustaining employment by reason of mental or physical disability which commenced prior to the child's 21st birthday.

A child of your common-law or same gender Spouse is considered a Dependant if the child meets the foregoing age requirements, is chiefly dependent on you or your common-law or same gender Spouse for financial support, and has resided with you for a minimum of 12 consecutive months.

A child of your common-law or same gender spouse must be listed on this form. If listed later, he/she will have to wait for 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.

Member Signature _____ Spouse Signature _____

Signature of Dependent Child Age 18 or Over _____

Signature of Dependent Child Age 18 or Over _____

Date _____