

**REGISTRATION
FORM**

HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN

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

**ANSWER ALL QUESTIONS AND SIGN THE REVERSE SIDE OF THIS FORM.
THIS FORM WILL BE RETURNED TO YOU IF IT IS INCOMPLETE.**

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 and your dependents. 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 the 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 <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE or <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> COMMON LAW		SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		DATE OF EMPLOYMENT DAY MO. YEAR		EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME

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

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

Are your Dependants living with you? Yes No

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

No Yes – Name _____ SIN _____
Insurance Company/Policy# _____

Do any of your Dependants also work for HyLife Foods?

No Yes – Name _____ SIN _____

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 at the same time a Direct Deposit is made to your Bank Account.

Email address:

PLEASE TURN OVER

DEFINITION OF DEPENDANT

“**Dependant**” means the Spouse and Dependant Children of an Employee, who live in Canada.

“**Spouse**” means a person who is legally married to you, or a person living with you in a common-law relationship if such person is publicly represented by you as your husband or wife and such person has been living with you for a period of at least: one continuous year if neither of you are married or 3 continuous years if either of you remains legally married to another person. At any one time, only the person designated on this form will be considered to be your Spouse.

“**Dependent Child**” means your unmarried, natural or legally adopted child, step-child, or the child of your common-law Spouse, who is:

- (a) under 18 years of age; or
- (b) 18 years of age or older but less than 25 years of age and is attending a full time course of education at a recognized school, college or university; or
- (c) 18 years of age or older and is not capable of self-sustaining employment by reason of mental or physical disability which commenced prior to the child’s 18th birthday.

A child is considered to be a Dependent if you or your common-law Spouse contribute regularly to the support of such child. A child of a common-law Spouse must have lived with you for a minimum of 12 consecutive months.

Your common-law Spouse and the children of your common-law 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 administrator’s records for at least 12 months in order to be considered to be your Dependent.

AUTHORIZATION

I hereby authorize the HYLIFE FOODS/UFCW LOCAL NO. 832 BENEFIT PLAN TRUST FUND, and its administrator, to deposit claim payments to my Bank Account as identified on the front of this form. I understand this information will be kept confidential and secure, and that it will only be used for the purposes identified herein. I further understand that I am personally responsible for the confidentiality and security of my personal information that may be sent to me by email. If my eligibility for plan coverage ends, the direct deposit agreement will be automatically cancelled.

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 above. 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 _____