



Coughlin & Associates Ltd.
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I.B.E.W. LOCAL UNION 2085 HEALTH & WELFARE AND PENSION TRUST FUNDS



APPLICATION FOR GROUP COVERAGE

Please print clearly and complete both sides of this form, in INK. Sections 2 through 5 are to be completed by the plan member.

1. Privacy

This section explains Coughlin & Associates Ltd.'s commitment to privacy.

Please read carefully.

Protecting Your Personal Information

As Administrator of your Group Benefit Plans, at Coughlin & Associates Ltd, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. The information is used to determine your eligibility for coverage and to administer the group benefits plan.

Why do we ask for your Social Insurance Number?

We ask for your SIN for:

- Income tax reporting purposes, to comply with the requirements under the Federal Income Tax Act, and
- Administrative purposes, such as ensuring the accuracy and integrity of your personal information by using your SIN as an internal identification number for you.

Use of name and address

From time to time, Coughlin & Associates Ltd. may use the address it has on file to provide you with additional information regarding the life insurance, benefits and/or pension coverage you are entitled to receive through your group benefits program. Your Consent allows Coughlin & Associates Ltd. to send additional information on these programs to you. Your name and address will not be used for any other purpose or disclosed to any other party, except where required by law. If you do not wish to receive such material, please contact Coughlin & Associates Ltd. at 204-942-4438 or, toll free, 1-888-204-1234 and your name and address will be removed from the contact list.

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

***Note: As per pension legislation, the dates of declaration and dissolution of common-law relationships must be provided.**

last name	given name(s) (in full) and initials
street	city and province
postal code	telephone
date of birth (day/month/year)	social insurance number
Gender	Marital Status
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
	<input type="checkbox"/> Separated/Divorced <input type="checkbox"/> Common-Law*
	<input type="checkbox"/> Widowed
*Date of Marriage or Common-Law Relationship Change of Status	*Change of Status due to:
day	<input type="checkbox"/> Legal separation <input type="checkbox"/> Death
month	<input type="checkbox"/> Cessation of co-habitation <input type="checkbox"/> Divorce
year	

3. Dependent Information

This section is to be completed by the plan member. Please print clearly, in INK. For purposes of coordination of benefits the Insurance industry has established parameters that require the need for the following information in order to coordinate coverages with your spouses carrier (if applicable).

Spouse Information

last name	first name	middle initial
Gender		
<input type="checkbox"/> Male <input type="checkbox"/> Female		
date of birth (day/month/year)		

What group benefits coverage does your spouse have through an employer?

Healthcare	→ Does this include prescription drug coverage?
<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentalcare	Visioncare
<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> None

Dependent Information

If there are more than three dependents, please attach a separate list.

	Date of birth	Gender	Full time Student	Disabled Dependent
last name	(day/month/year)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
last name	(day/month/year)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
last name	(day/month/year)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please TURN OVER – Both sides of this application must be completed

Please complete:

Plan Name: **I.B.E.W. Local Union 2085**

Plan member name: _____

Date: _____

4. Beneficiary Designation

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The original copy of this form will be required for a life claim.

Please print clearly, in INK.

(We urge you to address these matters in a Will which should be coordinated with Legal Counsel and kept up to date.)

I hereby appoint the following revocable beneficiary(s) of any benefits payable under the Trust Fund(s) upon my death, and discharge the Trustees of the Plan to the extent of such payment. If no beneficiary is named, the distribution of your benefits will be paid to your Estate. If more than one beneficiary is named, **total distribution of the benefits must equal 100%.**

A. HEALTH & WELFARE BENEFICIARY DESIGNATION FOR LIFE BENEFITS

Beneficiary's Name(s)			Percent allocated	Relationship to plan member
_____	_____	_____	_____	_____
last name	first name	middle initial		
_____	_____	_____	_____	_____
last name	first name	middle initial		
_____	_____	_____	_____	_____
last name	first name	middle initial		

Contingent beneficiary – or Secondary beneficiary in the event the beneficiary(s) dies before me, the life benefit set out in the Health & Welfare plan is to be paid to:

Name of contingent beneficiary Relationship to plan member

B. PENSION BENEFICIARY DESIGNATION

Beneficiary's Name(s)			Percent allocated	Relationship to plan member
_____	_____	_____	_____	_____
last name	first name	middle initial		
_____	_____	_____	_____	_____
last name	first name	middle initial		
_____	_____	_____	_____	_____
last name	first name	middle initial		

Contingent beneficiary – If all of the above beneficiaries die before me, the pension death benefit set out in the pension plan is to be paid to:

Name of contingent beneficiary Relationship to plan member

TRUSTEE APPOINTMENT

If designating a beneficiary who is a minor (under age 18) or who lacks legal capacity to receive the proceeds, you **must** appoint a trustee/administrator.

If you are designating a trustee/administrator, we recommend you consult with a legal advisor, and with any proposed trustee/administrator.

Trustee Name Relationship to plan member

5. Authorizations and Declarations

This section must be signed by the plan member.

Authorizations and Declarations

I hereby apply for coverage under I.B.E.W. L.U. 2085 H&W and Pension Trust Funds which are administered by Coughlin & Associates Ltd. I authorize:

- Coughlin to use my social insurance number to administer my coverage and benefits under the group benefits plan, when required;
- Coughlin, any healthcare provider, my insurer, Trustees, other insurance companies or benefit providers working with Coughlin to exchange information, when necessary, to determine my eligibility for coverage and to administer the group benefits plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorizations and Declarations Section is as valid as the original.

I authorize the following persons to request changes to my personal information or request information on my Health & Welfare and Pension Plan Benefits:

(Anyone that you name shall be authorized as your agent to request information).

(Anyone that you name shall be authorized as your agent to request changes.)

I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature: _____ Date: _____