



# MULTI-EMPLOYER HEALTH & WELFARE PENSION TRUST FUND ENROLMENT FORM

Please print clearly. Complete the form in ink, sign and date the form and return to your plan administrator for processing.

## INSTRUCTIONS

1. Complete sections 1 through 8
2. Sign and date the form (section 8)
3. Retain a copy for your files
4. Send original signed form to Coughlin & Associates Ltd. for processing.

Mail to:

Coughlin & Associates Ltd.  
PO Box 764  
Winnipeg, MB R3C 2L4

## 1. PLAN MEMBER INFORMATION

Union or Plan Name						
Member last name			Member first name			Member middle initial
Mailing address				City	Province	Postal code
Email address			Primary telephone		Secondary telephone	
Date of birth (yyyy/mm/dd)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French		Social Insurance Number
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married		Provide effective date of marital status (yyyy/mm/dd) _____			If common-law, confirm date of co-habitation (yyyy/mm/dd) _____	

## 2. COORDINATION OF BENEFITS

What type of coverage does your spouse/common-law partner have under his/her own group insurance plan?

- |   |   |
|---|---|
| Health care <input type="checkbox"/> Single | Dental care <input type="checkbox"/> Single |
| <input type="checkbox"/> Family             | <input type="checkbox"/> Family             |
| <input type="checkbox"/> No coverage        | <input type="checkbox"/> No coverage        |

## 3. SPOUSE AND / OR DEPENDANT INFORMATION

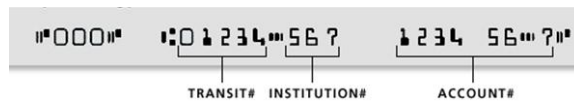
Dependant last name	Dependant first name	Date of birth (yyyy/mm/dd)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled child <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to plan member

## 4. BANKING INFORMATION

If you wish to have your claim payments deposited directly into your bank account, provide your banking information. You can locate your banking information on your personal cheque, financial institution statement or by contacting your financial institution directly.

If you wish to receive confirmation by email, provide your email address. Your Explanation of Benefits (EOB) will be available on the Plan Member Portal. Deposits will be made within two to five working days following the approval of your claim.

Sample cheque number pattern



Enter your banking information in the fields below

Note: Line of credit cheques or US accounts are NOT eligible.

Transit # (5 digits)	Institution # (3 digits)	Account # (maximum 12 digits)

## 5. APPOINTMENT OF BENEFICIARY

The following beneficiary appointment will apply to **ALL ELIGIBLE BENEFITS** insured under your group insurance plan with the above mentioned plan sponsor. If you wish to appoint separate beneficiary(ies) of different benefits under your plan, please complete the "BENEFICIARY DESIGNATION (BY BENEFIT) FORM". If you wish to make the beneficiary nomination irrevocable, please complete the "IRREVOCABLE BENEFICIARY DESIGNATION FORM".

If you do not nominate a beneficiary, the proceeds will be paid to your Estate. You are responsible for ensuring the validity of your designation.

Revocable: means that the designation of a beneficiary can be changed without the beneficiary's consent.

Irrevocable: means that the designation of a beneficiary cannot be changed without the written consent of the beneficiary and unless certain requirements are met. The irrevocable designation of a minor cannot be changed until they reach the age of majority.

**Quebec residents:** Unless otherwise specified, the designation of a legal spouse or spouse joined in a civil union as beneficiary is IRREVOCABLE. Unless otherwise specified, the designation of any other person as beneficiary is REVOCABLE. I hereby make the below beneficiary designation:

Revocable, I may change this beneficiary designation at any time.

**All other provinces:** The designation of beneficiary is REVOCABLE unless otherwise specified by completing the "IRREVOCABLE BENEFICIARY DESIGNATION FORM".

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies), where permitted by law:

Beneficiary last name	Beneficiary first name	Beneficiary date of birth (yyyy/mm/dd)	Relationship to plan member	Percentage
				%
				%
				%
				%
				%
				<b>TOTAL 100%</b>

## 6. PENSION PLAN BENEFICIARY INFORMATION

Beneficiary last name	Beneficiary first name	Beneficiary date of birth (yyyy/mm/dd)	Relationship to plan member	Percentage
				%
				%
				<b>TOTAL 100%</b>

## 7. TRUSTEE APPOINTMENT (not applicable to Quebec residents)

Complete this section if any designated beneficiary(ies) is/are under the age of majority or lack legal capacity. This section is not applicable to Quebec residents where appointments are governed by the Quebec Civil Code.

I appoint \_\_\_\_\_ as Trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release Coughlin & Associates Ltd., the plan sponsor, and the insurance company from any further liability.

## 8. OTHER INFORMATION

You will be enrolled in the health & benefit plan and pension trust fund once you satisfy the eligibility criteria defined in your group plan benefit and pension booklets.

## 9. AUTHORIZATION & DECLARATION

I hereby apply for coverage under the policy holder's group plans. I authorize the deduction from my pay of any contribution I must make toward the cost of these and any future benefits. I authorize Coughlin & Associates Ltd. ("Coughlin") to use my Social Insurance Number for the purposes of government reporting. I authorize Coughlin to collect, use, maintain and disclose my personal information with the following persons, organizations or parties: health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies and their reinsurers and/or service providers; employers or former employers; my local union; plan trustees and auditors for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility (as applicable). When providing personal information 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 form is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member signature	Date (yyyy/mm/dd)
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**Protecting your personal information:** Coughlin recognizes and respects every individual's right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at [www.coughlin.ca](http://www.coughlin.ca), or send a written request to our Privacy Officer by mail or by email at [privacy@coughlin.ca](mailto:privacy@coughlin.ca).