Coughlin & Associates Ltd.
P.O. Box 764
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1-888-204-1234

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.
Completion of this form does not guarantee that you or your dependents are eligible for benefits

1. Privacy

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

Please read carefully.

Protecting Your Personal Information

The Administrator of your Group Benefit Plans is Coughlin & Associates Ltd. (Coughlin). At Coughlin, 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. We use the information 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.**

union or plan name ____________________

last name ____________________ given name(s) (in full) and middle initial ____________________

mailing address ____________________ city and province ____________________ postal code ____________________

telephone ____________________ email address ____________________

date of birth (year/month/day) ____________________ social insurance number ____________________

Gender

☐ Male ☐ Female

Marital Status

☐ Single ☐ Married*
☐ Separated ☐ Common-Law*
☐ Widowed ☐ Divorced

*Date of Marriage or Commencement of Common-Law Relationship

year ________ month ________ day ________

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 ________

date of birth (year/month/day) ________

Gender

☐ Male ☐ Female

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

Healthcare

☐ Single ☐ Family ☐ Waived ☐ None

→ Does this include prescription drug coverage? ☐ Yes ☐ No

Dentalcare

☐ Single ☐ Family ☐ Waived ☐ None

Visioncare

☐ Single ☐ Family ☐ Waived ☐ None

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

Dependent Information	Date of Birth	Relationship to Insured	Gender	Full Time Student	Disabled Dependent
last name / first name / middle initial	(year/month/day)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
last name / first name / middle initial	(year/month/day)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
last name / first name / middle initial	(year/month/day)		Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐

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

Please complete:
Plan Name: _______________ _______________ 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 Health benefits payable under the Trust Fund upon my death, and discharge the Trustees of the Plan to the extent of such payment. (Note: Your designation of a beneficiary will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation). 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 <u>must</u> 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

……………………………………………..

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your pension death benefits, if applicable

Note: Under pension legislation, your spouse (or common-law partner, if he/she fulfills the legal common-law definition) is automatically the designated beneficiary unless your spouse completes a government form waiving this benefit.

Please print clearly, in INK.

In the event that I do not have a spouse at the date of my death, I hereby appoint the following revocable beneficiary(s) of any Pension benefits payable under the Trust Fund upon my death, and discharge the Trustees of the Plan to the extent of such payment. (Note: Your designation of a beneficiary will not be revoked or changed automatically by any future marriage or divorce. 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 <u>must</u> equal 100%.**

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 – or Secondary beneficiary in the event the beneficiary(s) dies 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

……………………………………………..

Note: Not required if the plan member has already completed a written Trust Agreement.

TRUSTEE APPOINTMENT

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

<u>Authorizations and Declarations</u>

I hereby apply for coverage under the group benefits plan(s) 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, 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 <u>Authorizations and Declarations</u> 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:** ______________
year / month / day

PLEASE RETURN TO COUGHLIN & ASSOCIATES LTD.