UNITE HERE HEALTH & WELFARE PLAN and/or UNITE HERE PENSION PLAN
Enrollment and Beneficiary Designation Form

Personal Information

IS THIS A: □ NEW Application □ CHANGE of Information

Last Name, First Name:_____

Address: _____ APT.#_____

City: _____ Province:_____ Postal Code: _____

Telephone Number Home: : _____ Work: _____ Email: _____

Date of Birth: _____ / _____ /_____ Sex: □ M □ F S.I.N. : _____- _____- _____
(Year) (Month) (Day)

Place of Employment: _____ Department: _____

Marital Status: □ Single □ Married □ Common Law for at least 1 year (proof must be submitted)

Employment Status: □ Full-time □ Part-time

Do you have coverage under your spouse's plan? □Yes □ No

Have you worked before at another employer while a member of this Union? □Yes □ No

Dependent Information (For children over age 21, proof of student enrollment must be submitted each year).

Spouse's Last Name	First Name		Date of Birth (Year) / (Month) / (Day)
_____	_____		_____ / _____ /_____
Child's Last Name	**First Name**		
1. _____	_____	□ M □ F	_____ / _____ /_____
2. _____	_____	□ M □ F	_____ / _____ /_____
3. _____	_____	□ M □ F	_____ / _____ /_____
4. _____	_____	□ M □ F	_____ / _____ /_____
5. _____	_____	□ M □ F	_____ / _____ /_____

Please send the completed original form to:

Soben Ltd.
150 Consumers Road, Suite 302
Toronto, ON M2J 1P9

Telephone: 416-498-8338 FAX: 416-498-4591 Toll Free: 1-888-887-6879
Email: benefits@soben.ca Website: www.UniteHereBenefits.ca

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Revocable Beneficiary Designation

If I complete this beneficiary designation section, I revoke any previous beneficiary designations and I request that any death benefits be payable in equal shares (unless I state otherwise) to the following, provided that they survive me.

If I do not complete this Beneficiary designation section, I request that my previous beneficiary designation under the Plans remain unchanged. If I have never made a beneficiary designation under the Plans, I understand that my beneficiary will be my Estate.

I understand that (a) I may change my beneficiary at any time, and (b) neither Soben Ltd. nor the Plans assume any responsibility for the validity of this designation.

UNITE HERE Health & Welfare Plan (Life Insurance and Accidental Death Insurance)

Full Name	Relationship to you	Birth date (if under age 21)
_____	_____	_____
_____	_____	_____

UNITE HERE Pension Plan

Complete only if you are a member of the Pension Plan. **If you have a spouse and you wish to name a pension beneficiary other than your spouse, a "Waiver of Pre-Retirement Death Benefit" form must be completed and returned to Soben Ltd**. This form can be obtained from Soben Ltd.

Full Name	Relationship to you	Birth date (if under age 21)
_____	_____	_____
_____	_____	_____

Complete ONLY IF your beneficiary is under 21 years old

□ CHECK here if your beneficiary is under 21 years old and you wish to name someone to receive payment on his/her/their behalf

Full Name	Relationship to you
_____	_____

is hereby appointed Trustee to receive any payment due on or after my death to any beneficiary designated on this form who is a minor on the date such payment is due.

Employee Certification

I understand that the collective agreement between my employer(s) and the UNITE HERE Local 75 will determine whether I participate in the UNITE HERE Health & Welfare Plan and/or the UNITE HERE Pension Plan, and that my benefits will be based the terms of those Plan(s) and the terms of any insurance policies. I authorize the Plan(s) and their agents to (a) use my social insurance number for identification purposes and (b) use the information provided on this form for the purposes of paying claims and administering the Plan(s). I certify all the above information to be true and correct.

Employee's Signature: _____ **Date: _____**

Employer's Authorization

Employee's Status: □ Full-time □ Part-time Employee's Hire Date: _____ / _____ /_____
(Year) (Month) (Day)

Employer's Signature: _____ **Date: _____**