# UNITE HERE HEALTH & WELFARE 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: _________ / _________ /________ S.I.N. : _____________- _____________- _____________
**(Year) (Month) (Day)**

Place of Employment: ________________________________________________ Department: ___________________________________

Gender: □ M □ F □ Non-binary □ (Specify): _____________________

Marital Status: □ Single □ Married □ Common Law 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 | | Date of Birth (Year) | (Month) | (Day) |
|---|---|---|---|---|---|---|
| 1. | ____________________ | ____________________ | □ M □ F | ________ / | ________ / | ________ |
| 2. | ____________________ | ____________________ | □ M □ F | ________ / | ________ / | ________ |
| 3. | ____________________ | ____________________ | □ M □ F | ________ / | ________ / | ________ |
| 4. | ____________________ | ____________________ | □ M □ F | ________ / | ________ / | ________ |
| 5. | ____________________ | ____________________ | □ M □ F | ________ / | ________ / | ________ |

Please send the completed original form to:

**Soben Management 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

**December 2022**

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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 Plan remain unchanged. If I have never made a beneficiary designation under the Plan, 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 Management Ltd. nor the Plan 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) |
|---|---|---|
| ________________________________ | ______________________ | _____________________ |
| ________________________________ | ______________________ | _____________________ |

**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 (the "Plan") and that my benefits will be based the terms of the Plan and the terms of any insurance policies. I authorize the Plan and its 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. 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:** ________________________