Ironworkers Ontario Benefit Plan

Enrolment/Change Form

Instructions

This is a two-page form. Please complete both pages in full. Incomplete or inaccurate information could result in refusal of benefits or delays in processing your claims. Be sure to sign and date this form, and attach a completed life insurance beneficiary card, pension fund beneficiary form, and (if applicable) a waiver of pre-retirement death benefit. Return to:

Ontario Ironworkers/Rodmen Benefit Plan Administrators Corporation
111 Sheppard Avenue East, North York, Ontario M2N 6S2
Telephone 416-223-0383 or 1-800-387-8075

Type of change	Effective date	Type of change	Effective date	Type of change	Effective date
☐ New member	Day / Month / Year	☐ Add/change child*	Day / Month / Year	☐ Other (specify)	
☐ Add/change spouse*	Day / Month / Year	☐ Spouse change in coverage*	Day / Month / Year		Day / Month / Year

* Must be provided to Administrator within 31 days of effective date of change.

1. Member Details

Last Name: ____________________ First Name: ____________________

Middle Name: ____________________ Social Insurance Number: ____________________

Date of Birth: ____________________ (Day / Month / Year) Sex: ☐ Male ☐ Female

Province of Residence: ____________________ Union Local: __________ Trade: __________

Complete Mailing Address – Street: ____________________ Phone #: ____________________

City/Town: ____________________ Province: ____________________ Postal Code: ____________________

Country: ____________________ E-mail Address: ____________________

If you are covered for benefits under another employer, group or association plan, please check any box that applies:

☐ hospital ☐ prescription drug ☐ dental ☐ major medical ☐ travel

Do you have a spouse *(see definition below)* who qualifies for Ironworkers medical and dental benefits? ☐ **Yes or** ☐ **No** *(mark one)*
If yes, you must complete the following or your spouse will not be covered.

2. Spouse Details (only one spouse may be named)

Last Name: ____________________ First Name: ____________________

Middle Name: ____________________ Spouse's Social Insurance Number: ____________________

Date of Birth: ____________________ (Day / Month / Year)

Spouse's Complete Mailing Address – Street: ____________________

City/Town: ____________________ Province: ____________________ Postal Code: ____________________

If your spouse is covered for benefits under another employer, group or association plan, please check any box that applies:

☐ single ☐ family ☐ hospital ☐ prescription drugs ☐ dental ☐ major medical ☐ travel

Who qualifies as your spouse for major medical and dental benefits

A person who is living with you and is either:

- legally married to you, or
- not married to you but has lived with you in a conjugal relationship continuously for at least one year and is publicly represented by you as your spouse.

If you want to cover a common-law spouse after you join the plan, you must apply in writing to the Administrator. Your common-law spouse and any of his or her own children who are not also your children must wait one year from the date this application is received for coverage to begin.

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3. Children *List only your children who qualify (see definition below)*

Last Name	First Name	Sex Enter F or M	Date of Birth Day/Month/Year	If over age of 21 (Check if applicable) Full-time Student	 Disabled	Relationship to you (Child, stepchild, etc.)

Note: If you have children who qualify and do not list them, they will not be covered.

Who qualifies as your child

Your child or your spouse's child by birth or adoption who is claimed as a dependant for income tax purposes and is:

- unmarried, and
- not employed full time, and
- covered under a provincial health plan, and
- a resident in Canada,

and either

- under age 21 and living with you, or
- under age 21 and living with your former spouse somewhere in Canada (if you are making support payments), or
- a full-time student under age 25 who was covered under this plan before age 21 and is living in Canada, or
- any age and not capable of self-support because of a mental or physical disability and covered under this plan before age 21.

If you or your spouse are covered under another health or dental plan

According to the rules established by the Canadian Life & Health Insurance Association, claims should be submitted in the following order:

1. First to any plan that does not have rules about claiming from more than one plan.
2. If both plans have rules, a member or spouse must first submit his/her own claims to his/her own employer's plan.
3. Claims for covered children should be submitted first to the plan of the parent whose birthday comes earlier in the calendar year.
4. If a person is a member of two plans, claims are submitted in the following order:
   - the plan where the member is an active full-time employee,
   - the plan where the member is an active part-time employee,
   - the plan where the member is a retiree,
   - any plan where the member is covered as a dependant.

4. Privacy

The Trustees know that confidentiality of personal information is important. Any information you provide to us will be kept in a benefits file with the Administrator. Access to your information will be limited to:

- authorized staff, representatives of the plan, and the Administrator who require access in order to perform work related to the adjudication of claims and administration of the plans;
- individuals at the insurance companies and actuarial consulting firm appointed by the Trustees who require access in order to perform work related to the adjudication of claims and administration of the plans;
- individuals to whom you have granted access;
- individuals authorized by law.

You have the right to request access to the personal information in your file, and if necessary, correct any inaccurate information.

Authorization *(Must be completed)*

I authorize the use of my social insurance number by the Trustees of the Ontario Ironworkers Benefit and Pension Plans and their appointed agents for identification, administration and tax reporting purposes. I also agree to the collection, holding, sharing and use of my personal data for the following purposes:

- to determine eligibility for benefits;
- to process, adjudicate and pay claims;
- for ongoing plan management and cost analysis.

I certify that all information provided on this form is accurate and true.

Member Signature ______________________________ Date____________________
Day / Month / Year

I agree to the sharing of my personal information with my spouse for the purpose of benefits administration. ☐ Yes or ☐ No

Spouse Signature______________________________ Date____________________
Day / Month / Year

I agree to the sharing of my personal information with my spouse for the purpose of benefits administration. ☐ Yes or ☐ No