RODMEN

LOCAL 721 RODMEN'S BENEFIT FUND

ENROLMENT/CHANGE FORM

Instructions: This is a two-page form. **Please complete both pages in full. Even if you add a spouse or child, please list all dependents covered by the plan.** 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 form and a pension beneficiary form. Return to: Ontario Ironworkers/Rodmen Benefit Plan Administrators Corporation
111 Sheppard Avenue East, Toronto, 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	Day/Month/Year
☐ Add/change spouse	Day/Month/Year	☐ Spouse change In coverage*	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: _____ ☐ S.I.N. or ☐ Member Certificate Number: _____.

Date of Birth: _____ Union Local: _____ Trade: Rodman
Day / Month / Year

Complete Mailing Address – Street: _____ Phone #: _____.

City/Town: _____ Province: _____ Postal Code: _____.

Country: _____ Email Address: _____.

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

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

Do you have a spouse (see definition below) who qualifies for medical and dental benefits? ☐ Yes ☐ No (check one)

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

Last Name: _____ First Name: _____.

Middle Name: _____ ☐ S.I.N. _____.

Date of Birth: _____.
Day / Month / Year

Complete Mailing Address – Street: _____.

City/Town: _____ Province: _____ Postal Code: _____.

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

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

Your spouse is a person who is living with you and either legally married to you or not married to you but has lived with you in a conjugal relationship 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 children who are not also your children must wait one year from the date of this application is received for coverage to begin.

3. Children You must list *all* of 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 21, confirm if disabled	Relationship to you (Child, stepchild, etc.)
		Blank		No	
		Blank		No	
		Blank		No	
		Blank		No	
		Blank		No	

Note: If you have children who qualify and do not list then each time you complete this form, they will not be covered.

Who qualifies as your child

Your and your spouse's dependent child by birth or adoption who meet all of the following requirements:

- Unmarried,
- Not employed full time,
- Covered under a provincial health plan,
- Resident in Canada, and
- Under age 21(or any age if not capable of self-support due to physical or mental disability and already covered under this plan before reaching 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 plan, 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 dependent.

4. **Privacy**

The Trustees of the Local 721 Rodmen Benefit Plan 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 administration of the plan;
- individuals at the actuarial consulting firm appointed by the Trustees who require access in order to perform work related to the administration of the plan;
- 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.

5. **Authorization**

I authorize the use of my social insurance number by the Trustees of the Local 721 Rodmen Benefit Plan 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 to to determine eligibility for benefits, to process, adjudicate and pay claims, and for ongoing plan management and cost analysis.

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

Member's Signature _____ Date _____ *

* Day / Month /Year

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

Spouse's Signature _____ Date _____ *

* Day / Month /Year

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