MEMBER INFORMATION CARD

EMPLOYER	
IS THIS A CHANGE TO INFORMATION PREVIOUSLY SUBMITTED?	YES ☐ NO ☐

MEMBER LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL INSURANCE NUMBER

APT. NO.	NUMBER/STREET	CITY/TOWN	PROVINCE	POSTAL CODE

DATE OF BIRTH DD / MM / YYYY	MALE ☐ FEMALE ☐	FAMILY ☐ SINGLE ☐	HEALTH INSURANCE NUMBER	UNION LOCAL	HOME PHONE NO.

FAMILY MEMBERS TO BE COVERED

SPOUSE OR COMMON LAW PARTNER DATE OF MARRIAGE OR COHABITATION _____

LAST NAME	FIRST NAME	MALE ☐ FEMALE ☐	DATE OF BIRTH DD / MM / YYYY

CHILDREN LAST NAME	FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

GROUP INSURANCE BENEFICIARY

I appoint the following beneficiary with respect to any Group Life Insurance I may become entitled to. I reserve the right to change the beneficiary from time to time, subject always to the provisions of any law or governmental regulations. If the named beneficiary predeceases me and no other has been appointed, any proceeds will be payable to my Estate.

LAST NAME	FIRST NAME / MIDDLE INITIALS	RELATIONSHIP TO MEMBER

APT. NO.	NUMBER/STREET	CITY/TOWN	PROVINCE/POSTAL CODE	DATE OF BIRTH MTH DAY YR

COLLECTION OF PERSONAL INFORMATION

Benefit Plan Administators (Atlantic) Limited (BPA) on behalf of the Trust Fund collects personal information from you, your employer or your former employer and your union local, to determine eligibility and benefit entitlements under your Plan. Your employment history may be shared with your union local for the purpose of monitoring the contributions required to be made under the terms of the Collective Agreement.

Your personal information is kept confidential and safeguarded. BPA will only release relevant personal information to your eligible dependents specific to their benefit entitlements. Your personal information (and the personal information of your eligible dependents) may be disclosed to insurance carriers, auditors and other benefit providers so that they can perform services in connection with the administration of the Plan. Disclosure will be limited to the specific information required for a particular purpose. Personal information may also be disclosed as required or permitted by law.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match information with the correct member file.

I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature _____ Date _____

Please complete **both sides** of the card in detail. Any benefits you may be entitled to under your Benefit Plan may not be paid until this card is **completed, dated, signed and filed with the Plan Administrator.** A new card is required to change any information.

PLEASE RETURN *MEMBER INFORMATION CARD* TO:
BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
49-55 ELIZABETH AVENUE, SUITE 202, ST. JOHN'S, NEWFOUNDLAND A1A 1W9