			PENSION	N MEME	BER	INFORMATIO	N CAF	RD			
	P	A	PLAN NAME					EMPLOY	ER		,
								UNION LOCAL			
LAST NAME			FIRST NAME			MIDDLE NAME			SOCIAL INSU	JRANCE	NUMBER
APT. NO. NUMBER/STR		REET	CITY/	CITY/TOWN		PROVINCE			POSTAL CODE		
DATE OF BIRTH	ATE OF BIRTH MALE C		MARRIED/	LAW SINGLE		DIVORCED	HOME PHONE NO.				
PENSION PLAN BE I appoint the followitime to time, subject appointed, any productions	ng benefi t always	ciary to red	distorts of any law o	penefits to verne	whicl ental	h I may become entit regulations. If the na	iled to. I med ber	l reserveneficiary	e the right to predeceas	o chan ses me	ge the beneficiary from and no other has been
LAST NAME				FIRST NAME / MIDDLE INITIALS				RELATIONSHIP TO MEMBER			
APT. NO. NUMBER/STREET				CITY/TOWN				PROVINCE/POSTAL COL		ODE	DATE OF BIRTH
COLLECTION OF D	EDCONA	LINEODA	MATION								
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 specified be disclosed to true	ic to thei ust comp ne admir	r benefit e panies, ins nistration	entitlements. You surance carriers, of the Plan. Disc	r personal actuaries, losure will	info aud be	rmation (and the pe itors and other ber limited to the spe	ersonal i nefit pro	nforma viders	ation of you so that th	ur elìgil ey car	tion to your eligible ble dependents) may n perform services in a particular purpose.
I understand that rand to match infor					ricte	st confidence and	will only	be us	ed for inco	me ta	x reporting purposes
I consent to the co	ollection,	, use and	disclosure of per	sonal info	rmat	tion as stated abov	/e.				

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

Date

Member's Signature

PLEASE RETURN PENSION MEMBER INFORMATION CARD TO:

BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
49-55 ELIZABETH AVENUE, SUITE 202, ST. JOHN'S, NEWFOUNDLAND A1A 1W9