Trustees of the Southern Interior Health & Welfare

Enrolment and Change Form

☐ **New Member** ☐ **Reinstatement** ☐ **Change of Information**

EMPLOYER/PLAN ADMINISTRATOR – Please complete Part 1 of this application and provide to the member to complete their information	**MEMBERS** – Please complete Parts 2 through 7 of this application and return to your employer to submit to the Plan Administrator

PLEASE PRINT CLEARLY IN INK. Sign, date and submit your application as soon as possible.

1. EMPLOYER / PLAN ADMINISTRATOR

Name of Employer				Division/Subdivision Name	
Division #	**Subdivision (if applicable)**	**Class**	**Plan Code (if applicable)**	**Union Local** ☐ 405 ☐ 417 ☐ 423	**Policy Number** 907704
Employee Legal First Name		**Middle Initial**	**Last Name**	**Job Title**	
Employment Type	☐ Full Time ☐ Designated Part Time		**Hours per week**	**Employee Payroll #**	
Date of hire or rehire (MM-DD-YYYY)		**Extended Health (EHC) effective date (MM-DD-YYYY)***		**Notes**	

*The rules regarding benefit effective dates are complicated – for a new hire health benefits are effective the first of the month following the date of hire. See the SIHWP Admin Guide for further details about benefit effective dates. You MUST notify AGA when an employee is eligible for additional benefits following completion of the probationary period. Please use the Notes box above if there are any additional comments you want to make regarding the eligibility dates.

Employer's Authorized Signature	**Date (MM-DD-YYYY)**	**Contact information for person completing Part 1**

2. MEMBER INFORMATION

If you were covered by this Plan or another IWA-Forest Industry Health & Welfare Plan within the last 18 months, complete the following

Last Employer Name: **Division:**

Date of Birth (MM-DD-YYYY)	**Gender** ☐ Male ☐ Female ☐ Other ☐ Prefer not to disclose	**Social Insurance Number**

Member Street Address	**City**	**Province**	**Postal Code**

Member Mailing Address	

Member Email Address	**Member Phone Number**

3. SPOUSE INFORMATION – list your eligible spouse for Extended Health and Dental coverage

☐ Check this box if your spouse and/or your dependent children are covered under another employer who participates in the Southern Interior Health & Welfare plan. Duplicate coverage is not allowed when you and your spouse are both working for employers who participate in the SIHWP. If your spouse is eligible for coverage under any employer participating in this Plan, each of you should enroll under your own ID number and only one of you may enroll dependent children, however you should list them below for information.

Legal First Name	Initial	Last Name	Dep Birthdate (MM-DD-YYYY)	Gender	Relationship to You	Date of Marriage or Cohabitation
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐ Common-Law ☐ Married	

4. DEPENDENT CHILDREN – list your eligible children for Extended Health and Dental coverage

Legal First Name	Initial	Last Name	Dep Birthdate (MM-DD-YYYY)	Gender	Full Time Student*	Dependent with Disabilities**
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐Yes ☐ No	☐Yes ☐ No
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐Yes ☐ No	☐Yes ☐ No
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐Yes ☐ No	☐Yes ☐ No
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐Yes ☐ No	☐Yes ☐ No
				☐ Male ☐ Female ☐ Other ☐ Not disclosed	☐Yes ☐ No	☐Yes ☐ No

* Dependent Children must be financially dependent on you & must not be married or in any other formal union. A student is an overage dependent who is a full-time student attending an education institution recognized by Canada Revenue Agency.

** Dependent(s) with Disabilities require additional information. Please provide a copy of one of the following with completed enrolment form: a) CRA approved Application for Disability Tax Credit OR b) Persons with Disability CRA approval letter OR c) Disabled Dependent Application (obtain from your Plan Administrator)

Member Name:_____

5. LIFE INSURANCE and ACCIDENTAL DEATH BENEFICIARY DESIGNATION				
Beneficiary Legal First Name	**Middle Initial**	**Last Name**	**Relationship to You**	**Share%**

6. TRUSTEE APPOINTMENT (Complete ONLY if any Designated Beneficiary listed above is under the age of majority)			
Legal First Name	**Middle Initial**	**Last Name**	**Relationship to You**

7. DECLARATION OF UNDERSTANDING and CONSENT

I, the undersigned, hereby apply to be enrolled as a member of the Southern Interior Health & Welfare Plan ("the Plan"). I understand that completion of this form does not in itself entitle me to benefits under the Plan – qualification for benefits is in accordance with the rules of the Plan.

I agree to the terms and conditions of the Plan and authorize my employer to deduct the required contributions (if any) from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse the Plan up to the amount advanced to me pending such settlement or judgement. I consent to the Plan Administrators, Pacific Blue Cross and other insurers or claims payors collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrolment or coverage under the Plan.

I consent to the disclosure of my personal information to the Trustees of the Southern Interior Health & Welfare Plan and their authorized agents and representatives (including the Plan Administrators and Pacific Blue Cross) for the purpose of assessing and providing benefits coverage. I also consent to the collection, use, and disclosure of my personal information and that of my dependents for the purposes of conducting inquiries or investigations to verify claims, and to ensure that my dental, pharmacy and other health service providers, dependents, or I have not made fraudulent or misleading claims or claims to which my dependents or I may not be entitled. I further agree that if it is found that my dependents or I participated in a false or misleading claim or made a claim or received benefits for which my dependents or I are not entitled, that the Plan Administrators and/or the insurers and claims payors may suspend our coverage, recover such amounts wrongly paid to me, and/or exercise the right of set-off.

I consent to the use of my social insurance number for tax and/or other statutory reporting purposes and as an identification number where it is required in the administration of the Plan.

I also consent to the disclosure of my personal information to my employer when required or permitted by law or by contract between the Plan Administrator and/or Pacific Blue Cross and my employer; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross privacy policy and Plan Administrator's privacy policy.

I give permission to contact me by email for purposes related to the Plan.

Member Signature Please print this document and sign and date the form in ink. Forms signed electronically do not constitute a valid life insurance beneficiary designation.	Date (mm-dd-yyyy)
Witness Signature Please print this document and sign and date the form in ink. Forms signed electronically do not constitute a valid life insurance beneficiary designation.	Date (mm-dd-yyyy)

Return completed form to the Plan Administrator:

Southern Interior Health & Welfare Plan
c/o AGA Benefit Solutions
301E – 675 Cochrane Drive, Markham, ON L3R 0B8
Phone: 1-800-218-7018 Fax: 905-477-2249 Email: sihwp@aga.ca