



PRIVACY STATEMENT

IUOE, Local 793 and OEBAC collects the information on this form for the purpose of processing member claims to benefits, to manage the Life and Health, Group Legal and Pension Benefits Plans, to obtain advice, and to assist members in respect of any claims they may have for government sponsored benefits, including benefits under the *Workplace Safety and Insurance Act*, the *Canada Pension Plan*, and the *Employment Insurance Act*. IUOE, Local 793 and OEBAC will not use or disclose personal information for any other purpose, except with the consent of the member, or if applicable, with the consent of the Dependent or Beneficiary, or where permitted or required to do so by law. Subject to contractual or legal restrictions, you may withdraw or refuse your consent to continued use and disclosure of your personal information. Such refusal or withdrawal of consent may prevent the provision of benefits to you and/or your beneficiaries.

PLAN MEMBER	This section allows you to provide your basic personal information.							
	Last Name		First and Middle Names		Date of Birth (yyyy-mm-dd)	Social Insurance Number	From your OEBAC Benefits Card Group #: 793 793X Certificate #:	
	Address		Unit #	City		Postal Code	Province (or State) and Country	Or, from your IUOE Local 793 Card Registration #:
	Email		Phone #		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (check your current status) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Married/cohabitating since (yyyy-mm-dd)

DEPENDANTS FOR LIFE AND HEALTH AND GROUP LEGAL BENEFITS	This section allows you to define who will be entitled to your Life and Health and Group Legal Benefits.								
	<p>1. Defining Dependents: The first line is always used for you and only to define if you have another health care plan. The second line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse. The remaining lines are used for your children. Always indicate how the person is related to you, for example: son, stepdaughter, etc. Note that only your spouse and your children who are not married and (a) are under the age of 21, or (b) are under the age of 25 if they are full time students, or (c) are disabled, can be defined as Dependents.</p> <p>2. Student: Check the appropriate box only if the Dependant is a child of yours who is enrolled as full-time student.</p> <p>3. Disabled: Check the appropriate box only if the Dependant is a child of yours who is disabled.</p> <p>4. Other Health Care Providers: Define here any other health provider plans that you or any of your Dependents may have. Leave the line blank if the Health plan for this person is the one provided by IUOE Local 793. The Name of the Plan Provider, the Group #, and the Certificate # can be found in the benefits card issued by the other health care provider.</p>								
	Dependant for the purpose of Health and Legal Benefits ¹					Other Health Care Provider ⁴ (needed to coordinate benefits)			
	Relationship to Plan Member	Full Name	Date of Birth (yyyy-mm-dd)	Student ²	Disabled ³	Name of the Plan Provider	Group #	Certificate #	Single or Family
	YOU	N/A	N/A	N/A	N/A				
	SPOUSE			N/A	N/A				

DIRECT DEPOSITS	This section allows you to participate in direct deposits for payments you may receive. The information about the bank account to use can be obtained from a cheque or from the bank.		
	Bank account to use		
	Banking Institution (3 digits)	Transit Number (5 digits)	Account Number (7 or more digits)

INQUIRERS	This section allows you to assign individuals who have your consent to interact with us on your behalf for inquiries about your Life and Health claims, Group Legal claims, your Disability, or your Pension. OEBAC will only interact with you or the appropriate individuals listed below.				
	Authorized Inquirer		Authorized to Inquire about		
	Name of the Individual	Relationship to You	Your Claims	Your Disability	Your Pension

BENEFICIARIES	<p>This section allows you to assign the percentages of the monies that will be paid to the selected Beneficiaries for the <u>Life Insurance and Accidental Death (Life & AD) Benefit</u>. Please note:</p> <ol style="list-style-type: none"> The first line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse. The remaining lines are used for all the other Beneficiaries. Always indicate how the person is related to you, for example: son, daughter, stepson, mother, cousin, friend, etc. You must assign a Trustee to act on behalf of Beneficiaries who are under the age of 18. The sum of all percentages in each allocation column must add to 100%. If you do not indicate % allocations or if the sum of the % allocations in a column is not equal to 100%, then the benefit of that column will be divided evenly among the listed beneficiaries. 					
	LIFE INSURANCE & ACCIDENTAL DEATH BENEFIT (AD&D) BENEFICIARY					
	Life Insurance and Accidental Death (Life & AD)Beneficiary			Benefit allocation %	Assigned Trustee (required if the beneficiary is a minor, under 18)	
	Relationship to Plan Member	Full Name	Date of Birth (yyyy-mm-dd)	Life & AD Benefit	Full name of the Trustee and relationship to the Beneficiary (e.g. uncle, lawyer, etc.)	Phone # or email of the Trustee
	SPOUSE			%		
				%		
				%		
				%		
				%		
				100 %		

BENEFICIARIES	<p>This section allows you to assign the percentages of the monies that will be paid to the selected Beneficiaries for the <u>Death Benefit (\$2,000)</u>. Please note:</p> <ol style="list-style-type: none"> The first line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse. The remaining lines are used for all the other Beneficiaries. Always indicate how the person is related to you, for example: son, daughter, stepson, mother, cousin, friend, etc. You must assign a Trustee to act on behalf of Beneficiaries who are under the age of 18. The sum of all percentages in the allocation column must add to 100%. If you do not indicate % allocations or if the sum of the % allocations in a column is not equal to 100%, then the benefit of that column will be divided evenly among the names with a check mark. 					
	DEATH BENEFIT (\$2,000 policy) BENEFICIARY					
	Beneficiary			Benefit allocation %	Assigned Trustee (required if the beneficiary is a minor, under 18)	
	Relationship to Plan Member	Full Name	Date of Birth (yyyy-mm-dd)	\$2000.00 Death Benefit	Full name of the Trustee and relationship to the Beneficiary (e.g. uncle, lawyer, etc.)	Phone # or email of the Trustee
	SPOUSE			%		
				%		
				%		
				%		
				%		
				100 %		

This section allows you to assign the percentages of the monies that will be paid to the selected Beneficiaries for the Pension Plan Death Benefit. Please note:

1. **By law, the Pension Plan Death Benefit is paid to your qualifying spouse if married or Living Common Law over 3 years and not living separately from you at the time of death.** If you do not have a qualifying spouse, or if your qualifying spouse dies before you die, this Death Benefit will be paid to your beneficiary. Please refer to the pension booklet for definition of spouse.
2. The first line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse.
3. You do not need to specify a percentage allocation of your pension for your spouse because if you die before your spouse, your spouse who meets the definition for pension purposes at time of death will receive 100% of any remaining pension benefits.
4. The other lines are used for all the other Beneficiaries. Always indicate how the person is related to you, for example: son, daughter, stepson, mother, cousin, friend, etc. You must assign a Trustee to act on behalf of Beneficiaries who are under the age of 18.
5. The sum of all percentages in each allocation column must add to 100%.
6. If you do not indicate % allocations or if the sum of the % allocations in a column is not equal to 100%, then the benefit of that column will be divided evenly among the names with a check mark.

PENSION PLAN BENEFICIARY

BENEFICIARIES

			Benefit allocation %	Assigned Trustee (required if the beneficiary is a minor, under 18)	
Relationship to Plan Member	Full Name	Date of Birth (yyyy-mm-dd)			
SPOUSE (MARRIED OR COMMON LAW)			100% to a qualifying spouse		
Primary Pension Beneficiary (in the event there is no qualifying spouse)			Benefit allocation %	Full name of the Trustee and relationship to the Beneficiary (e.g. uncle, lawyer, etc.)	Phone # or email of the Trustee
			%		
			%		
			100 %		
Contingent Pension Beneficiary (in the event the primary is not alive at the time of your death)			Benefit allocation %	Full name of the Trustee and relationship to the Beneficiary (e.g. uncle, lawyer, etc.)	Phone # or email of the Trustee
			%		
			%		
			100 %		

SIGNATURE

By signing below,

- I solemnly declare that all the information provided in this form is accurate and complete and that I will promptly notify OEBAC of any changes;
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use my personal information, and to disclose it to each other and to other persons and organizations, for the purpose of processing the benefits to which I am or may become entitled, to obtain advice in any matters related to the administration of the Life and Health, Group Legal, and Pension Benefits Plans and the provision of benefits, and to assist me in respect of any claims I have for government sponsored benefits, including benefits under the *Workplace Safety and Insurance Act*, the *Canada Pension Plan*, and the *Employment Insurance Act*;
- I acknowledge that completing this form does not give me a right to benefits under the Life and Health, Group Legal, and Pension Benefits Plans, and that eligibility for benefits under the Plans is governed by the eligibility criteria set out in the official plan and trust document(s).
- I acknowledge that I may withdraw this consent in the future but by doing so I may prevent the delivery of my benefits; and
- I authorize OEBAC to answer questions about my Life and Health Benefits, my Disability Benefits, and my Pension Benefits to the authorized inquirers indicated in this form.

Plan Member's Signature

Date Signed (yyyy-mm-dd)

Plan Member's printed name and last name

SUPPORTING DOCUMENTATION REQUIRED BY OEBAC

Please ensure you have attached all required documents to this form as described below:

- If in the DEPENDANTS section you indicated that you have a child between 21 and 25 years of age who is a full-time student, then attach a letter verifying fulltime enrollment from the corresponding University or College.
- If in the DEPENDANTS section you indicated that you have a disabled Dependant older than 21 years of age, then attach a certificate from a physician confirming the disability.
- If in the DIRECT DEPOSITS section you provided a bank account, then attach a void cheque of that account.
- If in the BENEFICIARIES section you selected a lawyer as a Trustee, then attach the lawyer's business card.

For more details about eligibility criteria and whether you are currently eligible for benefits under one or more of the Plans, please contact OEBAC.

Once you have all the attachments described above, staple them to this form and mail everything to:

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON, L6L 2X9