



TEAMSTERS' NATIONAL BENEFIT PLAN

Application Form

MEMBER DATA

Name of Employee (PRINT) Last name First Middle Sex M. or F. Address Street City Province Postal Code Phone Date of Birth DD MM YYYY Social Insurance Number Employment Status: Regular Employee Dependent Contractor Other Teamster Local 31 Member Yes No

DEPENDENTS

List all dependents on the reverse side of this form.

BENEFICIARY APPOINTMENT (see reverse for beneficiary information)

I hereby revoke any previous beneficiary designations made by me in respect of any benefits payable upon my death under the provisions of the Teamsters' National Benefit Plan (and any group insurance contract the trustees may select from time to time to underwrite these benefits). I hereby designate the following beneficiary under the Teamsters' National Benefit Plan (and any group insurance contract the trustees may select from time to time to underwrite these benefits) to receive any benefits payable upon my death, and I reserve the right to change this designation at a later date.

Name of Beneficiary (Please print clearly) Relationship to you Beneficiary's date of birth

If more than one beneficiary is named, settlement will be made in equal shares to the beneficiary or beneficiaries that survive the insured, unless otherwise provided by the Plan's terms, the group insurance contract or as required by law. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured.

I certify that the persons listed on this form are dependents as defined by the Teamsters' National Benefit Plan (the Plan). I further certify that all information provided on this form is true and correct to the best of my knowledge. I authorize the Plan to use the above information for record keeping purposes and for the administration of the Plan. In addition, I authorize that my Social Insurance Number may be used as my personal identification number for claims information and contributions for me and all other purposes of the Teamsters' National Benefit Plan. I further understand and agree that any and all information provided to the Plan may be used or disclosed by the Plan to agents of the Plan as necessary for the administration of the Plan and/or to determine eligibility for benefits. I understand that benefits are determined by the Board of Trustees in accordance with the Plan Text and the Agreement and Declaration of Trust. A photocopy of this authorization is as valid as the original.

DATED MEMBER SIGNATURE

EMPLOYER STATEMENT (To be completed by the Employer)

Date of Employment as a REGULAR Employee Effective Date of Coverage per Collective Agreement EMPLOYER NAME Authorized Signature

**DEPENDENTS TO BE COVERED**

List all dependents for whom coverage is to be provided. If medical coverage (MSP) is to be included, tick the appropriate box and complete the appropriate MSP application form.

Name of Dependent	Sex (M or F)	Date of Birth (Day, Month Year)	Relationship	Coverage	
				Include MSP	No MSP
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>

Important Note: Dependent children may be covered until the end of the month in which they turn 19 years of age. They may continue to be eligible beyond that date (but not beyond age 25) provided they are in full time attendance at a recognized school or university. If this is the case, please contact our office for the appropriate forms.

Coverage may also be provided for dependent children of any age who are mentally or physically handicapped to the extent that they are incapable of self support.

In all cases, dependent children must be unmarried, must reside with you and must rely upon you principally for support

**NOTES**

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This form should be completed and returned to your employer for submission to the Plan. If you have any questions regarding completion of this form, please contact:

Teamsters' National Benefit Plan  
 1610 Kebet Way, Port Coquitlam, B.C. V3C 5W9  
 Phone 604-552-2650 : Fax 604-552-2653 : Toll Free 1-888-478-8111