BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

Return to:
J & D Benefits Inc.
8901 Woodbine Ave., Suite 228
Markham, ON L3R 9Y4
TEL: 1-800-218-7018 FAX: 905-477-2249

GROUP BENEFITS CHANGE FORM

Member Name *First* *Middle Init.* *Last*	**Union ID #**

Please complete ONLY the sections below with the information you wish to change, then sign and date the form

NAME/ ADDRESS CHANGE

New Name *First* *Middle Initial* *Last*

New Address *Apt #* *Street*

City *Province* *Postal Code*

Email address

Effective Date of Change M D Y

CHANGE IN BENEFIT COVERAGE

I wish to change my status to: ☐ Single ☐ Family

Reason for change

- ☐ Marriage/Civil Union
- ☐ Common-law *(provide date you began living together)*
- ☐ Coverage under spouse's plan terminated
- ☐ Divorce
- ☐ Other (provide explanation)_____

Date of change M D Y

SPOUSE INFORMATION

	First Name	Middle Initial	Last Name *(only if different from member)*	Sex	Date of Birth
☐ Add ☐ Delete				☐ Female ☐ Male	M D Y

☐ My spouse does not have extended health and/or dental coverage

☐ My spouse has the following benefits: Extended Health: ☐ Single ☐ Family Dental: ☐ Single ☐ Family

Name of Insurance Company_____

Effective Date of Spouse's Benefits:_____

Policy #: _____ ID#:_____

SECTION 2

DEPENDENT INFORMATION

Please list all dependents.

First Name	Last Name *(only if different from employee)*	Middle Initial	Sex	Date of Birth	For children age 21 or older please specify: Full time student	Disabled Dependent
Child			☐ Female ☐ Male	M D YYYY	Yes ☐	Yes ☐
					Name of School and ID#	
Child			☐ Female ☐ Male	M D YYYY	Yes ☐	Yes ☐
					Name of School and ID#	
Child			☐ Female ☐ Male	M D YYYY	Yes ☐	Yes ☐
					Name of School and ID#	
Child			☐ Female ☐ Male	M D YYYY	Yes ☐	Yes ☐
					Name of School and ID#	

If you have additional dependents please list them on a separate sheet and attach to this form.

Member Name *First* *Middle Initial* *Last*	Union ID #

British Columbia M.S.P. Opt Out

Complete this section only if you are already covered for MSP and are not completing the Health Insurance BC Application for Group Enrolment

I certify that I and all my eligible dependents have coverage under the British Columbia Medical Services Plan through:

A. ☐ an individual plan
B. ☐ other employer/plan sponsor

If B, please list the name of the plan sponsor your coverage is under _____

I understand that I will not be covered for this benefit under the Motion Picture Workers Health Benefits Plan unless applied for at a later date.

Signature _____ **Date** _____

BENEFICIARY DESIGNATION

Beneficiary(ies) designated on this form will replace any beneficiaries designated on previous group enrolment or change forms

First name	Last name	Relationship	Date of Birth	%

FOR QUEBEC MEMBERS: Where Quebec law applies and you have designated your married or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable", below.

I hereby make the above beneficiary designation: ☐ Revocable, I may change this beneficiary designation at any time.

If changing an irrevocable beneficiary, the beneficiary being removed must sign below.

Irrevocable beneficiary's signature: _____ **Date:** _____

TRUSTEE DESIGNATION: Complete only if designating a beneficiary who is a minor or who lacks legal capacity. It is recommended that you consult with a legal advisor, and with any proposed trustee/administrator.
For Quebec Applicants Only – Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity will be paid to his/her tutor(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and the Plan Administrator has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section.

Trustee full name	Relationship	Date of Birth

MEMBER AUTHORIZATION AND COMPANY DECLARATION

This section MUST be signed and dated in INK by the plan member

At J&D Benefits Inc., the personal information we collect concerning you and your dependents is kept in strict confidence and used only for the purposes you have authorized. Your personal file will be kept at J&D Benefits Inc.'s (J&D) offices. You have the right to request access to your personal information and, if necessary, correct any inaccurate information and/or make changes to current information whenever necessary. In order to do so, send a written request to J&D Benefits Inc., 8901 Woodbine Avenue, Suite 228, Markham, ON, L3R 9Y4.

Access to your personal information will be limited to J&D's employees and providers in the performance of their jobs, individuals to whom you have consented access, and persons authorized by law. For the purposes of audits and administrative reporting, J&D may release your Policyholder statistical financial information without personal identifiers.

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If changing information on my spouse and/or dependent children, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their coverage under my Plan Sponsor's group plan.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my plan sponsor and J&D Benefits Inc., its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my plan sponsor's group insurance plan.

I AGREE that a photocopy of this authorization shall be as valid as the original.

Member Signature:	**Date Signed:**