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 ENROLMENT FORM

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

SECTION 1

SPOUSE INFORMATION

Marital status	☐ Single ☐ Common Law ☐ Married/Civil Union ☐ Separated ☐ Divorced ☐ Widowed			If common law, date cohabitation started:	M D YYYY	
First Name *Middle Init.* *Last Name*				**Spouse Date of Birth** M D YYYY	**Sex** ☐ Female ☐ Male	
☐ My spouse does not have extended health and/or dental coverage	☐ My spouse has the following benefits:	Extended Health: ☐ Single ☐ Family				
		Dental: ☐ Single ☐ Family				
	Spouse group policy number	**Spouse ID#**	**Spouse insurance company**	**Spouse employer**		

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#	
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 Init.* *Last*	**Union ID #**

SECTION 3

British Columbia Medical Services Plan Opt Out

IF YOU COMPLETE THIS SECTION THE IATSE 891 BENEFITS OF FILM ACTIVE HEALTH PLAN WILL NOT COVER YOUR PREMIUMS FOR THE BC MEDICAL SERVICES PLAN.

IF YOU WANT TO BE COVERED, COMPLETE THE "BC MSP APPLICATION FOR GROUP ENROLMENT" FORM

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

A. ☐ an individual plan (you pay the premiums and will continue to pay the premium)
B. ☐ other employer/plan sponsor (premiums are paid by another group plan)

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 IATSE891 Benefits of Film Active Health Plan unless applied for at a later date.

Signature **Date**

SECTION 4

Member Authorization & Company Declaration

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

I HEREBY APPLY for the benefits which I am or may become eligible for, subject to any waiver indicated, under my Policyholder's group insurance plan and CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my Policyholder and J&D Benefits Inc., its employees, and the insurer(s) of the group insurance plan, their reinsurers and their service providers for the purpose of administration, claims processing and the enrolment of myself and my dependents in my Policyholder's group insurance plan.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

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 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.

Member Signature:	**Date Signed:**