DRYWALL, ACOUSTIC, LATHING AND INSULATION LOCAL 675 LIFE AND HEALTH BENEFIT PLAN

MEMBER INFORMATION CHANGE FORM

Please fill in your Last and First Name, as well as your Certificate Number (Union I.D.), and complete ONLY the information that has changed. Sign and return to the Plan Administrator.

Last Name	First Name	Date of Birth Day Month Year	Certificate Number (UNION I.D.)

CHANGE IN: HOME / MAILING ADDRESS

Apt	Address	City, Town or Village

Province	Postal Code	Phone	Email
		( )	

CHANGE IN: MARITAL STATUS

☐ Never married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union *(for Quebec only)*

If you have a spouse, complete the spousal information section below. The definition of eligible spouse can be found in your Benefit Plan Booklet.

☐ Common Law	☐ Married
Date of Co-habitation: Day Month Year	**Date of Marriage:** Day Month Year

CHANGE IN: SPOUSAL INFORMATION

	Last Name	First Name	Middle Init.	Date of Birth	Gender
Add ☐ Delete ☐				Day Month Year	Male ☐ Female ☐

CO-ORDINATION OF BENEFITS INFORMATION:

Are your spouse and children, if any, covered for health and dental with another insurance company through your spouse's employer?

NO ☐ YES ☐

*****Please provide information for ALL required fields*****

	Single	OR	Family
Health	☐		☐
Drugs	☐		☐
Vision	☐		☐
Dental	☐		☐

Spouse's Insurance Company:

Policy #:

Spouse's Coverage Effective Date:

CHANGE IN: DEPENDENT INFORMATION

Add	Change	Delete	Last Name (if different), First Name	Gender	Date of Birth (Day, Month, Year)	Student **	Disabled
☐	☐	☐					
☐	☐	☐					
☐	☐	☐					

** Proof of full-time attendance at an accredited school, college or university must be provided annually if the child is over age. Please refer to your booklet.

I hereby authorize the Plan Administrator to use the information provided by me on this card to administer my benefits. I further consent to the release of this information to my insurer, if applicable and required by my insurer, and to my local union office for authorization, if required under this plan

I hereby certify that all the statements and information on this form are true.

Member's Signature ______________________ **Date** ______________________

 Plan Administrator: **Manion, Wilkins & Associates Ltd**, 500-21 Four Seasons Place, Toronto, ON M9B 0A5