Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan
Registration/Change of Registration and Declaration of Beneficiary

PLEASE NOTE: This Registration Form is a legal document and replaces all previous Registration Forms.
Complete all sections in ink, (front and back) sign and return within 31 days of receiving it.
Coverage may be suspended pending receipt of a properly completed Registration Form.

SECTION 1

Member Information

Local Union No.			
Name (Last)	(First)	Sex (circle) M F	Date of Birth M D Y
Address (Street)		Social Insurance Number	
City	Prov	Postal Code	Telephone Number

SECTION 2

Spouse's Information

Indicate if ☐ spouse or ☐ common-law spouse

If Common Law, please complete Declaration on reverse.

Name (Last)	(First)	Sex (circle) M F	Date of Birth M D Y
Address (Street)	City	Prov	Postal Code

SECTION 3

Spouse's Coverage

Do not include coverage you may have as spouse under Member's Plan.

✔	PLEASE CHECK ONE OF THE FOLLOWING:
	My spouse has coverage for group benefits. (If spouse has group benefits, please complete the section to the right in full.) Date of Hire:____________________________ Employer's Name:
	My Spouse's employer does not offer group benefits. Date of Hire:____________________________ Employer's Name:
	My spouse is not employed. If changed: Date left Employment:_____________________ Date coverage terminated:

BENEFITS PROVIDED BY SPOUSE'S EMPLOYER

Benefit	Yes/No (circle)	Single/ Family (circle)	Effective Date (Mo / Day /Yr)
Drug	Y N	S F	
Dental	Y N	S F	
Vision	Y N	S F	
Major Medical	Y N	S F	

Do not include Provincial Health coverages.
Please complete ALL sections.

SECTION 4

Beneficiary for Life & Accident Insurance

Name
Relationship
Address
If beneficiary is under 18 years of age, please complete Declaration Appointing Trustee

DECLARATION APPOINTING TRUSTEE

I do hereby appoint _____________________________ as Trustee to receive any amount due to any beneficiary under 18 years of age and declare the receipt of such Trustee shall be a good discharge to the insurer for the amount so paid;

And I do hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at ______________________ this _______ day of___________, 20______.
(City)

______________________________ ______________________________
Signature of Witness Signature of Insured

PLEASE COMPLETE REVERSE SIDE AS WELL

SECTION 5

Dependent Information

Name (Last)	(First)	Relationship	Date of Birth (Mo/Day/Yr)

SECTION 6

If your dependents have coverage through anyone other than yourself or your current spouse, please complete the following

Name of Insured Person Providing Coverage:

Relationship to Dependent: | Date of Birth of Insured Person (Mo/Day/Yr):

Employer of Insured Person:

Which parent/guardian do dependents live with:

SECTION 7

Declaration of Common-Law Spouse

Please complete if your common-law spouse has not been registered with the Fund office for more than one year

I, ____________________________, do solemnly declare that I consider ________________________________
(Member)
to be my common-law spouse and our relationship as such commenced on the ______ day of ___________, 20___,

and has continued to the present time. I make this declaration conscientiously believing it to be true, and knowing

that it is of the same force and effect as if made under oath.

Participant's signature:

Declared before me at _____________ in the Province of________________ this __________day of __________ 20,____.

Name (please print):

My appointment expires on:

Commissioner for Oaths for the Province of:

PLEASE NOTE: This form must be sworn by a Commissioner for Oaths.

SECTION 8

I hereby apply for the benefits for which I am or may become eligible under the group plan ("Benefit Plan") established by my employer. In order to participate in the benefit program established by my employer and to apply for the benefits for which I or my spouse or dependents may be eligible, my social insurance number is required for identification and for income tax purposes. I consent to the use of my social insurance number for those purposes and also consent to the disclosure of my social insurance number to third parties who require it for the purpose of adjudicating claims and maintaining the benefit program. I also consent to the use and disclosure of my personal information or my spouse and dependents personal information, such as the administrator of the plan, the insurer and any professional advisors or consultants when that personal information is needed for the purpose of adjudicating claims or in order to maintain the benefit program. I authorize the release of statistical information (excluding specific medical details) regarding submitted claims (whether submitted on my behalf or on behalf of my spouse or dependents) to my employer or to other third parties such as professional advisors or consultants. I also direct and authorize my employer to deduct from my salary or wages any required contributions which I must make personally in order to become eligible for and remain a member of the benefit program. I certify that the information provided on this form is true and accurate. I understand that if any statement made herein is incomplete or false, any coverage granted may be voided in whole or in part.

Signature: Date

Please return to:

Funds Administrative Service Inc.
9th floor, 9707-110 Street
Edmonton, AB T5K 3T4
Phone: (780) 452-5161
Toll Free: 1-800-770-2998