COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd. is a People Corporation company

P.O. Box 3517 | Station C | Ottawa, ON K1Y 4H5 | T: 613-231-2266 or 1-888-613-1234 | F: 613-231-2345 | www.coughlin.ca

CANADIAN MERCHANT SERVICE GUILD WESTERN BRANCH BENEFIT PLAN ENROLMENT / CHANGE FORM

Please print clearly. Complete the form in ink, sign and date the form and return to your plan administrator for processing.

INSTRUCTIONS

Member:
1. Complete sections 1 through 6 if applicable.
2. Sign and date the form (section 7).
3. Return to your employer for processing.

Employer:
1. Complete section 8, and sign and date section 9.
2. Retain a copy for your files.
3. Send original signed form to Coughlin & Associates Ltd. for processing.

Mail to:
Coughlin & Associates Ltd.
PO Box 3517 Station C
Ottawa, ON K1Y 4H5

1. TYPE OF CHANGE

Plan sponsor/Group name				Effective date (yyyy/mm/dd)
CMSG Western Branch Benefit Plan – Pacific Pilotage Authority	☐ New member	☐ Name change	☐ Change of spouse or dependant child	
	☐ Change of coverage	☐ Beneficiary change	☐ Other: _____	

2. PLAN MEMBER INFORMATION

Member last name	Member first name	Member middle initial	
Mailing address	City	Province	Postal code
Email address	Primary telephone	Secondary telephone	

Date of birth (yyyy/mm/dd) ☐ Male ☐ Female

Language of correspondence ☐ English ☐ French

Marital status ☐ Single ☐ Widowed ☐ Common-law ☐ Divorced ☐ Separated ☐ Married

Provide effective date of marital status (yyyy/mm/dd) _____

If common-law, confirm date of co-habitation (yyyy/mm/dd) _____

3. COVERAGE SELECTION

Coverage can only be waived if you are covered under another group plan with similar coverage.

Dental care ☐ Single ☐ Family

4. COORDINATION OF BENEFITS

Do you, your spouse, or dependant children have coverage under another group benefits plan or health plan or government plan? ☐ Yes ☐ No

If yes, provide the following information:

- Who does the other plan belong to? ☐ Self ☐ Spouse ☐ Ex-spouse ☐ Full-time student

First name	Last name	Date of birth (yyyy/mm/dd)
Name of insurance company	Plan number	Plan member ID number

- What type of coverage does your spouse and dependant children have under his/her own group benefits plan?
  Dental care ☐ Single ☐ Family ☐ No coverage

If other coverage pertains to a child, please provide spouse's (or ex-spouse's) date of birth (yyyy/mm/dd) _____

5. SPOUSE AND DEPENDANT CHILDREN INFORMATION

	Last name	First name	Date of birth (yyyy/mm/dd)	☐Male ☐Female	Full-time student ☐Yes ☐No	Disabled child ☐Yes ☐No	Relationship to plan member
☐ Add ☐ Remove							
☐ Add ☐ Remove							
☐ Add ☐ Remove							
☐ Add ☐ Remove							
☐ Add ☐ Remove							

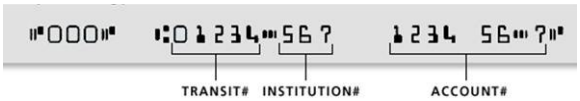
6. BANKING INFORMATION

Complete this section **only** if you are providing new or updated information.

By providing your banking information, your medical and/or dental claim payments will be deposited directly into your bank account. You can locate your banking information on your personal cheque, financial institution statement or by contacting your financial institution directly.

Your deposit will be confirmed by email and your Explanation of Benefits (EOB) will be available on the Plan Member Portal. Deposits will be made within two to five working days following the approval of your claim.

Sample cheque number pattern



Enter your banking information in the fields below

Note: Line of credit cheques or US accounts are NOT eligible.

Transit # (5 digits)	**Institution #** (3 digits)	**Account #** (maximum 12 digits)

7. AGREEMENT AND AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PERSONAL INFORMATION

Agreement and Authorization. By signing this form:

(1) You are applying for coverage under the plan sponsor's group insurance plan ("Plan"), and you authorize the required deductions from your salary or wages for any contribution you must make toward the cost of the benefits for which I am enrolled, if any, in accordance with the provisions of the Plan.

(2) You authorize us, Coughlin & Associates Ltd. ("Plan Administrator"), a People Corporation company, to use and disclose the information you provide in this form as described below. You also agree to notify us immediately of any changes to the information you provide in this form.

(3) You certify that the information you have provided is true, correct, and complete to the best of your knowledge and you certify that, if you have provided information about a spouse, dependant child, beneficiary, or trustee, you are authorized to provide such information. You agree that a photocopy or electronic copy of your signed form is as valid as the original.

Use of personal information.

(1) We use and disclose your plan member information to:
   (a) Determine your, your spouse's, and your dependant children's eligibility for benefits under the Plan, arrange for your benefits under the Plan, administer the Plan and your participation in the Plan, audit, manage, and assess the Plan and your benefit claims, investigate your claims, pay benefits to you, and comply with regulatory requirements, and for analytical purposes.
   (b) Verify your identity and conduct searches to locate you, or your beneficiaries.
   (c) Respond to questions about the Plan and benefits under the Plan.

(2) We use and disclose date of birth and gender information for actuarial valuation of the Plan and benefits, to determine eligibility of dependant children for benefits, and when necessary to verify identity.

If you are required to participate in the Plan, you may not withdraw your consent for this use and disclosure of personal information for mandatory benefits. If you withdraw your consent for any optional benefits, then you may no longer be enrolled for those benefits.

Use of optional personal information. If you provide any of the information described below, you may withdraw your consent for us to use and disclose this information by sending your request in writing to the Plan Administrator or our Privacy Officer using the contact information below.

1. If you provide beneficiary information, any benefits paid on your death that are not required to be paid to your spouse, will be paid to the specified beneficiaries. If you do not provide the beneficiary information, the death benefits will be paid to your estate.
2. If you designate a beneficiary who is under the age of 18, and this beneficiary becomes entitled to receive a benefit under the Plan upon your death, then we will pay this benefit in trust to the trustee you identify.
3. If you provide your banking information, any medical or dental benefits to which you are entitled will be deposited into your back account.

Disclosing personal information. The information provided in this form may be disclosed, when necessary, to:

1. Our and our affiliates' employees, contractors, and professional advisors who require the information to perform their duties related to the uses of personal information described above.
2. Service providers we retain to assist us with our obligations related to the Plan, which may include security of information, data processing, backup and programming, mailing, and people locating. Service providers may be located within or outside of Canada and the information may be subject to disclosure to government authorities.
3. Persons you authorize to access this information.
4. Persons legally authorized to view this information.
5. The financial institution related to your banking information, government agencies, actuaries, insurance companies and their reinsurers and service providers, your employer, and Plan trustees and union, and auditors.

Optional Communications

☐ By checking this box, you consent to receive electronic communications about our other products and services or products and services of our affiliates and service providers.

Member signature	Date (yyyy/mm/dd)

Protecting your personal information. We recognize and respect your right to privacy. When personal information is provided to us, we establish a confidential file that is kept in our facilities or in the facilities of an organization that we authorize. We limit access to information in your file to our personnel or other persons we authorize, who require the information to perform their duties with respect to the Plan, to persons to whom you have granted access, and to persons authorized by law. If you require more detail about how we protect your personal information or the other persons to whom we disclose your personal information, you may access our Privacy Policy at https://www.peoplecorporation.com/privacy/ or contact our privacy officer by mail sent to Coughlin & Associates Ltd., 1403 Kenaston Blvd., Winnipeg, MB, R3P 2T5, or by email sent to privacy.officer@peoplecorporation.com.

TO BE COMPLETED BY EMPLOYER ONLY

8. PLAN SPONSOR / EMPLOYER CONFIRMATION

Member ID/PIN	Date of hire (yyyy/mm/dd)	Dental care effective date (yyyy/mm/dd)	Dental care termination date (yyyy/mm/dd)

9. AUTHORIZATION & DECLARATION

I certify that the information given is true, correct and complete to the best of my knowledge.

Authorized name (please print)	Title or position
Authorized signature	Date (yyyy/mm/dd)