BENEFITS OF FILM
IATSE LOCAL 891 | ELHT

Group Benefits Enrollment Form

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

SECTION 1

SPOUSE INFORMATION

Marital Status	Single Common Law Married/Civil Union Separated Divorced Widowed	If common law, date cohabilitation started:	**M**	**D**	**YYYY**
First / Middle Init. / Last		**Spouse Date of Birth**	**Gender**		
		M D YYYY	Female GNC/NB Male Undisclosed		
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

DEPENDANT INFORMATION

Please list all dependants.

First Name	Last Name *(only if different from employee)*	Sex	Date of Birth	For children age 21 or older please specify:	
				Full-time student	Disabled Dependant
Child		Female Male GNC/NB Undisclosed	**M D YYYY**	Yes	Yes
				Name of School and ID#	
Child		Female Male GNC/NB Undisclosed	**M D YYYY**	Yes	Yes
				Name of School and ID#	
Child		Female Male GNC/NB Undisclosed	**M D YYYY**	Yes	Yes
				Name of School and ID#	
Child		Female Male GNC/NB Undisclosed	**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.

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SECTION 3 **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 AGA Benefit Solutions, 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 AGA Benefit Solutions, 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 AGA Benefit Solutions'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 AGA Benefit Solutions, 301E-675 Cochrane Dr, Markham, ON, L3R 0B8. Access to your personal information will be limited to AGA'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, AGA may release your Policyholder statistical financial information without personal identifiers	
	Member Signature:	**Date Signed:**

Common-Law Declaration Form

TO BE COMPLETED TO ADD YOUR DEPENDENTS TO YOUR BENEFIT COVERAGE IF YOU ARE LIVING IN A COMMON LAW RELATIONSHIP

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

I, _____ declare that I am living with and have publicly represented _____ as my spouse since
Member's Name *Common-law Spouse Name*

_____.
Date Cohabilitation Began

I further declare that the following children of myself or spouse, as defined above, are wholly dependent on me in accordance with the provisions of the Federal Income Tax Act.

_____ _____
Child's Name *Child's Name*

_____ _____
Child's Name *Child's Name*

_____ _____
Child's Name *Child's Name*

Member Signature: _____ **Date:**_____

Witness #1

I, _____declare that _____ has been living with
Witness Name, Address & Phone Number *Member's Name*
_____ and he/she has publicly represented her/him as his/her spouse for a period of at least 12 months.
Spouse Name

_____
Witness' Signature

Witness #2

I, _____declare that _____ has been living with
Witness Name, Address & Phone Number *Member's Name*
_____ and he/she has publicly represented her/him as his/her spouse for a period of at least 12 months.
Spouse Name

_____
Witness' Signature

Please contact AGA Benefit Solutions. at 1-800-218-7018 if you have any questions regarding this form
Return this form to: AGA Benefit Solutions. 301E-675 Cochrane Drive, Markham, ON, L3R 0B8, or email us benefitsoffilm@aga.ca