BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

Return to: AGA Benefit Solutions.
301E-675 Cochrane Drive
Markham, ON L3R 0B8
TEL: 1-800-218-7018, FAX: 905-477-2249
Email: benefitsoffilm@aga.ca

GROUP BENEFITS ENROLMENT 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 cohabitation started:	M D YYYY
First Name / Middle Init. / Last Name		**Spouse Date of Birth** M D YYYY	**Gender** ☐ 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

DEPENDENT INFORMATION

Please list all dependents.

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 Dependent
Child		☐ Female ☐ Male ☐ GNC/NB ☐ Undisclosed	M D YYYY	Yes ☐ Name of School and ID#	Yes ☐
Child		☐ Female ☐ Male ☐ GNC/NB ☐ Undisclosed	M D YYYY	Yes ☐ Name of School and ID#	Yes ☐
Child		☐ Female ☐ Male ☐ GNC/NB ☐ Undisclosed	M D YYYY	Yes ☐ Name of School and ID#	Yes ☐
Child		☐ Female ☐ Male ☐ GNC/NB ☐ Undisclosed	M D YYYY	Yes ☐ Name of School and ID#	Yes ☐

If you have additional dependents please list them on a separate sheet and attach to this form.

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:**

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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
Member's Name

_____ as my spouse since _____.
Common-law Spouse Name *Date Cohabitation 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
Witness Name, Address & Phone Number

_____ has been living with _____ and
Member's Name *Spouse Name*

he/she has publicly represented her/him as his/her spouse for a period of at least 12 months.

_____
Witness' Signature

Witness #2

I, _____declare that
Witness Name, Address & Phone Number

_____ has been living with _____ and
Member's Name *Spouse Name*

he/she has publicly represented her/him as his/her spouse for a period of at least 12 months.

_____
Witness' Signature

Please contact AGA Benefit Solutions at 1-800-218-7018 if you have any questions regarding this form