BENEFITS OF FILM+
IATSE 891 | 60+ HEALTH PLAN

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

# *BENEFITS OF FILM*+ OPT-IN FORM

To join the IATSE 891 60+ Health Plan, please complete this form, sign it and return it to AGA Benefit Solutions by mail, fax or email (scan or photo).

If you are not currently enrolled in the IATSE 891 Active Health Plan or Retiree Plan, you ***must also*** complete a Group Benefits Enrolment Form.

- **Name**.....
- **Union ID #**.....
- **Email address** (optional).....
- **Signature** (original) .....
- **Date** (dd/mm/yy) .....

Your coverage will go into effect on the first of the month after this form is received by AGA Benefit Solutions. Your level of coverage is set when you first opt into *Benefits of Film*+ and will not change if you work more hours.

# GROUP BENEFITS BENEFICIARY FORM

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

**I HEREBY REVOKE MY PREVIOUS BENEFICIARY DESIGNATIONS UNDER THE IATSE LOCAL 891 EMPLOYEE LIFE AND HEALTH TRUST AND DESIGNATE THE FOLLOWING AS BENEFICIARY(IES).**

**BENEFICIARY DESIGNATION**

**If you do not designate a beneficiary, payment of your benefits will be made to your ESTATE.**

**You may change this beneficiary designation at any time with written notice to AGA Benefit Solutions**

| First name | Middle Initial | Last name | Relationship | Date of Birth | % |
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**FOR QUEBEC RESIDENTS:** Where Quebec law applies and you have designated your married or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked

**TRUSTEE DESIGNATION:** Complete only if designating a beneficiary who is a minor. It is recommended that you consult with a legal advisor, and with anyone you name as trustee/administrator. The designating of a trustee through this form may not be sufficient to create a trust. Please consult a legal advisor in this matter.

**For Quebec Residents Only** – Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity will be paid to his/her tutor(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and the Plan Administrator has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section.

| Trustee full name | Relationship |
|---|---|
| | |

## Protecting Your Personal Information

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 Solution'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.

## Authorization

**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.

| Member Signature: | Date Signed: |
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| | |

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