IUOE Local 793

Pension and Benefits Administered by OEBAC

OPERATING ENGINEERS BENEFITS ADMINISTRATION CORP

Personal Information File

Member of the IUOE Local 793 Union

PLAN MEMBER

This section allows you to provide your basic personal information.

Last Name	First and Middle Names	Date of Birth (yyyy-mm—dd)	Social Insurance Number	From your OEBAC Benefits Card Group #: ☐793 ☐793X Certificate #:
Address	Unit # / City / Postal Code		Province (or State) and Country	Or, from your IUOE Local 793 Card Registration #:
Email	Phone #	Sex ☐Male ☐Female	Marital Status ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widow	Married/cohabitating since (yyyy-mm-dd)

DEPENDANTS FOR HEALTH AND LEGAL BENEFITS

This section allows you to define who will be entitled to your Health and Welfare and Group Legal Benefits.

1. Defining Dependants: The first line is always used for you and only to define if you have another health care plan. The second line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse. The other lines are used for your children. Always indicate how the person is related to you, for example: son, stepdaughter, etc. Note that only your spouse and your children who are not married and (a) are under the age of 21, or (b) are under the age of 25 if they are full time students, or (c) are disabled, can be defined as Dependants.

2. Student: Check the appropriate box only if the Dependant is a child of yours who is enrolled as full-time student.

3. Disabled: Check the appropriate box only if the Dependant is a child of yours who is disabled.

4. Other Health Care Providers: Define here any other health provider plans that you or any of your Dependants may have. Leave the line blank if the Health plan for this person is the one provided by IUOE Local 793. The Name of the Plan Provider, the Group #, and the Certificate # can be found in the benefits card issued by the other health care provider.

Dependant for the purpose of Health and Legal Benefits[1]					Other Health Care Provider[4] (needed to coordinate benefits)		
Relationship to Plan Member	**Full Name**	**Date of Birth (yyyy-mm-dd)**	**Student[2]**	**Disabled[3]**	**Name of the Plan Provider**	**Group #**	**Certificate #**
YOU	N/A	N/A	N/A	N/A			
SPOUSE			N/A	N/A			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			

DIRECT DEPOSITS

This section allows you to opt in direct deposits for payments you may receive. The information about the bank account to use can be obtained from a cheque or from the bank.

Bank account to use		
Banking Institution (3 digits)	**Transit Number (5 digits)**	**Account Number (7 or more digits)**

INQUIRERS

This section allows you to define individuals who will be allowed to interact with us on your behalf, usually for inquiries about your Health and Legal claims, your Disability, or your Pension. We will answer questions about your benefits only to you or to the appropriate individuals listed below.

Authorized Inquirer		Authorized to Inquire about		
Name of the Individual	**Relationship to You**	**Your Claims**	**Your Disability**	**Your Pension**
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

BENEFICIARIES

This section allows you to assign the percentages of the monies that will be paid to the selected Beneficiaries after you die – and in the case of your pension, after you and your spouse die. Please note:

1. The first line is always used for your spouse. Write "NO SPOUSE" as the Full Name if you don't have a spouse.
2. You do not need to specify a percentage allocation of your pension for your spouse because if you die before your spouse, your spouse will receive 100% of any remaining pension benefits.
3. The other lines are used for all the other Beneficiaries. Always indicate how the person is related to you, for example: son, daughter, stepson, mother, cousin, friend, etc. You must assign a Trustee to act on behalf of Beneficiaries who are under the age of 18.
4. Indicate the percentage of the Life Insurance and Accidental Death (Life & AD) Benefit, Death Benefit ($2000), and Pension that you want to allocate to each of the Beneficiaries. The number must be between 0% and 100%. A beneficiary can have a percentage allocated in one column and not in another.
5. The sum of all the percentages that you entered in each column must add to 100%.
6. If there are percentage allocations in a column but their sum at the bottom is not equal to 100%, then the benefit of that column will be divided evenly among those with number in that column.
7. If a column has no percentages allocated to any Beneficiary, then any applicable payment will be made to your Estate.

Beneficiary			Benefit selection and % allocation			Assigned Trustee (required if the beneficiary is a minor)	
Relationship to Plan Member	**Full Name**	**Date of Birth (yyyy-mm-dd)**	**Life & AD Benefit**	**Death Benefit**	**Pension at Death**	**Full name of the Trustee and relationship with the Beneficiary (e.g. uncle, lawyer, etc.)**	**Phone or email of the Trustee**
SPOUSE			**%**	**%**	N/A		
			%	%	%		
			%	%	%		
			%	%	%		
			%	%	%		
			%	%	%		
			%	%	%		
			0.00 %	0.00 %	0.00 %		

SIGNATURE

By signing below,

- I solemnly declare that all the information provided in this form is accurate and complete and that I will promptly notify OEBAC of any changes;
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any future additional information collected about me, my Dependants, or my Beneficiaries to process the benefits to which I am or may become entitled, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans;
- I acknowledge that completing this form does not give me a right to benefits under the Health and Welfare, Group Legal, and Pension Benefits Plans, and that eligibility for benefits under the Plans is governed by the eligibility criteria set out in the official plan and trust document(s).
- I acknowledge that I may withdraw this consent in the future but by doing so I may prevent the delivery of my benefits; and
- I authorize OEBAC to answer questions about my Health & Welfare Benefits, my Disability Benefits, and my Pension Benefits to the authorized inquirers indicated in this form.

Plan Member's Signature

Plan Member's printed name and last name

Date (yyyy-mm-dd)

SENDING TO OEBAC

Please ensure you have all the required attachments to this form as described below:

- If in the DEPENDANTS section you indicated that you have a child between 21 and 25 years of age who is a full-time student, then attach a Verification of Enrollment (VOE) from the corresponding institution.
- If in the DEPENDANTS section you indicated that you have a disabled Dependant older than 21 years of age, then attach a certificate from a physician confirming the disability.
- If in the DIRECT DEPOSITS section you provided a bank account, then attach a void cheque of that account.
- If in the BENEFICIARIES section you selected a lawyer as a Trustee, then attach the lawyer's business card.

For more details about eligibility criteria and whether you are currently eligible for benefits under one or more of the Plans, please contact OEBAC.

Once you have all the attachments described above, staple them to this form and mail everything to:

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON
L6L 2X9