BENEFITS OF FILM
IATSE 891 | ACTIVE HEALTH PLAN

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

GROUP BENEFITS CHANGE FORM

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

Please complete ONLY the sections below with the information you wish to change, then sign and date the form

NAME/ ADDRESS CHANGE

New Name	First / Middle Initial / Last			
New Address	Apt # / Street			
	City / Province / Postal Code			
	Email address			
Effective Date of Change	M D Y	**Gender Change**	☐ Female ☐ Male	☐ GNC/NB ☐ Undisclosed

CHANGE IN BENEFIT COVERAGE

I wish to change my status to: ☐ Single ☐ Family

Reason for change		**Date of change**
	☐ Marriage/Civil Union ☐ Common-law *(provide date you began living together)* ☐ Coverage under spouse's plan terminated ☐ Divorce ☐ Other (provide explanation)__________	M D Y

SPOUSE INFORMATION

	First Name	Middle Initial	Last Name *(only if different from member)*	Sex	Date of Birth
☐ Add ☐ Delete				☐ Female ☐ Male ☐ GNC/NB ☐ Undisclosed	M D Y

☐ My spouse does not have extended health and/or dental coverage

☐ My spouse has the following benefits:
Extended Health: ☐ Single ☐ Family
Dental: ☐ Single ☐ Family

Name of Insurance Company__________

Effective Date of Spouse's Benefits:__________

Policy #: ________ ID#:__________

SECTION 2

DEPENDENT INFORMATION

Please list all dependents.

First Name	Last Name *(only if different from employee)*	Gender	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.

Member Name First / Middle Initial / Last	**Union ID #**

BENEFICIARY DESIGNATION

Beneficiary(ies) designated on this form will replace any beneficiaries designated on previous group enrolment or change forms

First name	Last name	Relationship	Date of Birth	%

FOR QUEBEC MEMBERS: 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 "Revocable", below.

I hereby make the above beneficiary designation: ☐ Revocable, I may change this beneficiary designation at any time.

If changing an irrevocable beneficiary, the beneficiary being removed must sign below.

Irrevocable beneficiary's signature:________________________________ **Date:**__________________

TRUSTEE DESIGNATION: Complete only if designating a beneficiary who is a minor or who lacks legal capacity. It is recommended that you consult with a legal advisor, and with any proposed trustee/administrator.

For Quebec Applicants 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	Date of Birth

MEMBER AUTHORIZATION AND COMPANY DECLARATION

This section MUST be signed and dated in INK by the plan member

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 (AGA) 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, 675 Cochrane Drive Suite 301E, Markham, ON, L3R 0B8.

Access to your personal information will be limited to AGA benefit solutions 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.

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.

If changing information on my spouse and/or dependent children, I CONFIRM THAT I AM AUTHORIZED to disclose information concerning them for the purpose of determining their coverage under my Plan Sponsor's group plan.

On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my plan sponsor and AGA Benefit Solutions., its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my plan sponsor's group insurance plan.

I AGREE that a photocopy of this authorization shall be as valid as the original.

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