Employee Benefit Funds ADMINISTRATION LTD.

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REGISTRATION AND DECLARATION OF BENEFICIARY FORM

Electrical Industry Insurance Benefit Trust Fund of Alberta and Electrical Industry Pension Trust Fund of Alberta

PERSONAL INFORMATION CHANGES - Pension legislation requires that each Plan Member/Employee notify the Administrator of any and all changes to the Plan Member/Employee's address and contact information. When you have a Life Event, such as a marriage or birth of a child, you should update your Registration and Declaration of Beneficiary Form to ensure that your and your Dependents' information is up to date.

☐ New Form ☐ Updated Form

Member/Employee's Last Name (Legal Name)	First Name (Legal Name)	Preferred Name	Middle Initial

Birth Date (MMM/DD/YYYY) (e.g. Jan/01/2018)	Gender (Male/Female)	Social Insurance Number

Apt. No./Mailing Address	City/Town	Province	Postal Code

Home Phone/Land Line ( )	Cell Phone (include Area Code) ( )	E-mail Address

HEALTH & WELFARE / SPOUSE OR COMMON-LAW SPOUSE INFORMATION

A Spouse of a Plan Member/Employee means a person who, at the date of completion of this form, is either currently married to the Plan Member/Employee as result of a valid civil or religious ceremony, or is in a current and ongoing common-law relationship for a minimum of 12 consecutive months. The common-law relationship must include cohabitation in a conjugal relationship.

Spouse's/CL Spouse's Last Name (Legal Name)	First Name (Legal Name)	Middle Initial

Birth Date (MMM/DD/YYYY)	Mailing Address	Phone Number (include Area Code) ( )

☐ Spouse by Marriage ☐ Common-Law Spouse	Date of Marriage or Start of the Common-Law Relationship (MMM/DD/YYYY)

HEALTH & WELFARE - DEPENDENT CHILDREN (Under 21 Years of Age, or under 25 years of age if in school full-time)

Last Name (Legal Name)	First Name (Legal Name)	Birth Date (MMM/DD/YYYY)	Relationship (e.g. son, common-law son)

HEALTH & WELFARE - LIFE INSURANCE BENEFICIARY DESIGNATION

If one or more of the Beneficiaries listed below dies before me, any Benefit payable will be divided equally among the remaining Beneficiaries.
If this section is left blank, my Beneficiary will be my Estate.

Beneficiary's Legal Name (Last Name, First Name and Initial)	Percentage Allocated (Must Total 100%)	Relationship (e.g. spouse, common-law spouse, daughter, son, mother, etc.)
1.		
2.		
3.		

Beneficiary's Mailing Address	City/Town	Province	Postal Code	Phone Number (with Area Code)
1.				( )
2.				( )
3.				( )

PENSION

PENSION PARTNER INFORMATION (Spouse or Common-Law Spouse)

Pension Partner means, in relation to a Plan Member/Employee, a person who, at the date of completion of this form, is:

a.) married to the Plan Member/Employee and has not been living separate and apart from the Member/Employee for a continuous period longer than 3 years; or

b.) if a.) above does not apply, a person who, immediately preceding the date of completion of this form, has lived with the Plan Member/Employee in a marriage-like relationship for a continuous period of at least 3 years, or has lived with the Plan Member in a marriage-like relationship of some permanence, and provided there is a child of the relationship by birth or adoption.

☐ Check here if the Pension Partner is the same person as the Spouse indicated in the Spouse Information in the Health & Welfare section, then you do not need to complete the Pension Partner information below.

Pension Partner's Last Name (Legal Name)	First Name (Legal Name)	Middle Initial

Birth Date (MMM/DD/YYYY)	☐ Spouse by Marriage ☐ Common-Law Spouse	Phone Number (include Area Code) ( )

Date of Marriage or Date of Commencement of the Common-Law Relationship (MMM/DD/YYYY) (e.g. Jan 01/2018)

PENSION BENEFICIARY DESIGNATION

Under current legislation, the Pension Partner has entitlement to any death Benefit that may become payable, unless the Pension Partner waives their entitlement by completing a government "Pension Partner Waiver of Entitlement to a Death Benefit Before Pension Commencement in a Pension Plan" form (also known as a Form 5), **or** predeceases the Plan Member/Employee. A Form 5 can be obtained by contacting the Fund Office, or printed off the website at www.ebfa.ca

If at the time of my death I have no Pension Partner, or my Pension Partner has waived his/her rights to any death Benefit by completing a Form 5, I would like to designate the following Beneficiary(s) to receive my pension Benefits through the Pension Plan. If this section is left blank, my Beneficiary will be my Estate.

Beneficiary's Legal Name **Your Pension Partner Cannot Be a Beneficiary** (Last Name, First Name and Initial)	Percentage Allocated (Must total 100%)	Relationship (i.e. daughter, son, mother, etc.)
1.		
2.		
3.		

Beneficiary's Mailing Address	City/Town	Province	Postal Code	Phone Number (with Area Code)
1.				( )
2.				( )
3.				( )

TRUSTEE FOR A MINOR BENEFICIARY - Applies to Health & Welfare and Pension Plans
(To be designated for Beneficiaries under the age of majority)

Any payments becoming due, while the Beneficiary (or Beneficiaries) is a minor, will be made to the person named below in trust for the Minor Beneficiary. Payment to the Trustee for the Minor Beneficiary will discharge the Plans.

Trustee Name and Contact Information	Relationship to Plan Member/Employee

CONSENT & ACKNOWLEDGMENT

On behalf of myself and my eligible Dependents, I certify that the information on both sides of this form is true, correct and complete, to the best of my knowledge. I hereby revoke any previous direction or declaration which may be contrary to, or inconsistent with, the designation of the Beneficiary as contained herein. I authorize and consent to the collection, use, retention and release of information contained in, or pertaining to the form of other benefit-related personal information contained in files, now or in the future, to an insurer, Plan Administrator, Trustees, or any of their authorized representatives to assess eligibility of Benefits, to determine and adjudicate Benefits, to investigate any misuse of Benefits, and to overall manage the administration of Benefits. I also authorize the release of claim related information to my registered Dependents and to service providers from whom I, or my Dependents, have received products and/or services. I authorize the use of my Social Insurance Number for tax reporting identification purposes.

Completion of this Registration and Declaration of Beneficiary Form does not, in itself, entitle a Plan Member to Benefits. Please refer to the applicable Plan Booklet for eligibility details.

Signature_____ Date _____