Member Benefits Trust

IMPORTANT
PLEASE READ PRIOR TO COMPLETING FORMS

1) DECLARATION OF RESIDENCY

This form declares that you are a resident of Canada and are currently covered by a Provincial Health Care plan. Please remember to include your personal health care number, for BC residents this number can be found on your BC Care Card. If you are currently a non resident of Canada please contact the MBT office.

2) GROUP INSURANCE APPLICATION

This form is to ensure that the MBT has your correct information on file. Please note that including your dependents on this form does not automatically include them on your benefit plan. Please contact the MBT office for information on adding dependents to your benefit plan.

3) DESIGNATION OF PRIMARY BENEFICIARY FOR LIFE AND AD&D

This form gives you the opportunity to designate beneficiaries for Life Insurance and Accidental Death and Dismemberment Insurance for which you may be eligible. In addition to designating beneficiaries this form authorizes the MBT to deduct from your excess contribution reserve the required contribution, if any, towards the cost of your insurance as well as authorizes the MBT to use your Social Insurance Number for tax reporting, identification and in the administration of your benefits.

4) EXCESS CONTRIBUTION RESERVE - BENEFICIARY DESIGNATION FORM

This form gives you the opportunity to designate beneficiaries for your Excess Contribution Reserve Account. This account is made up of the contributions made by Producers and is used to pay for the cost of benefits. If, upon your death, there is a balance in the account, after administration costs, the balance will be paid out to your named beneficiaries.

***Please note if you are under the age of 19 your beneficiary must be your Estate.**

****WITNESS: FORMS MUST BE WITNESSED BY A PERSON 19 YEARS OF AGE OR OLDER, NOT BE A BENEFICIARY OR FAMILY MEMBER OR MBT STAFF MEMBER. PLEASE NOTE THAT THE WITNESS MUST WITNESS YOU SIGNING THE FORMS AND THEREFORE WILL SIGN THE FORMS THE SAME DAY AS YOU**

DECLARATION OF RESIDENCY

I, _____, DECLARE that I am a resident of Canada
(NAME AND UBCP #)

and that my current address is:

_____

_____

_____

I certify that (my family and) I am/are covered by a Provincial Heath plan, the details

of which are as follows: _____.
(PERSONAL HEALTH CARE NUMBER)

DATED this _____ day of _____, 20____.

_____
MEMBER NAME (PRINTED) & SIGNATURE

_____
WITNESS NAME (PRINTED) & SIGNATURE

Member Benefits Trust

Internal Use Only:

Date Joined UBCP: _____

Effective Date of Enrollment: _____

GROUP INSURANCE APPLICATION

PERSONAL DETAILS:

Membership No.:_____

Mr. Mrs. Ms. Miss Male Female SIN.: _____ Prov/State of Residence:_____

Legal Name: _____ Stage Name:_____
Last First Middle (If applicable)

Date of Birth: _____/_____/_____ Marital Status: Married Single Separated Common-Law* Divorced Widowed
(MM/DD/YYYY)

*If common-law, the following MUST be completed: "I have been living with _____ as my spouse since _____.
My common-law spouse and I are solely responsible financially for all our children claimed for insurance purposes.
I further verify that I am not required to provide coverage for any spouse to whom I am legally married, if any.

Occupation:

Actor-Principal Background Performer Stunt Performer** Animation Performer Stunt Co-ordinator Voice-over
**must have performed 2 paid stunts in the last 2 years to qualify as a "stunt performer"

SPOUSE DETAILS:

Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

DEPENDENT DETAILS: (Please list all eligible children/dependents details below)

1. Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

2 Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

3. Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

4. Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

5. Legal Name: _____ Male Female Date of Birth:___/___/_____
Last First Middle (MM/DD/YYYY)

ALTERNATE BENEFIT COVERAGE:

Are you, your spouse and children, if any, covered for health and dental benefits with another insurance company through your/their employer? Yes No – If yes, please complete the following:

Name of Insurance Company: _____

Name of Employer: _____

Member Benefits Trust

LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT - BENEFICIARY DESIGNATION

PERSONAL DETAILS: UBCP #:_____

Mr. Mrs. Ms. Miss Male Female SIN:_____ Prov/State of Residence:_____

Legal Name: _____ Stage Name:_____
Last First Middle (If applicable)

I DESIGNATE:

Last Name	First Name	Middle	Percentage (%)	Date of Birth (MM/DD/YYYY)	Sex	Relationship to you

Total: 100%

TRUSTEE DURING MINORITY CLAUSE: (The following must be completed if any primary beneficiary is a minor)

"I appoint _____, _____ to be my Trustee to hold any benefit payable hereunder
(Full legal name) (Relationship to you)
*to any minor child designated as a primary beneficiary until such child's majority (based on the Province/State where they reside) and any payment so made to the said Trustee shall discharge the **Member Benefits Trust** (MBT) to the extent of such payment."*

DESIGNATION OF CONTINGENT BENEFICIARY:

If you have no living primary beneficiary when you die, we will pay the benefits to your contingent beneficiary, named below. If you have no living beneficiary when you die, we will pay the benefits to the personal representative of your estate.

Last Name	First Name	Middle	Percentage (%)	Date of Birth (MM/DD/YYYY)	Sex	Relationship to you

Total: 100%

TRUSTEE DURING MINORITY CLAUSE: (The following must be completed if any contingent beneficiary is a minor)

"I appoint _____, _____ to be my Trustee to hold any benefit payable hereunder
(Full legal name) (Relationship to you)
*to any minor child designated as a contingent beneficiary until such child's majority (based on the Province/State where they reside) and any payment so made to the said Trustee shall discharge the **Member Benefits Trust** (MBT) to the extent of such payment."*

I hereby request that I be insured for the benefits for which I am or may become eligible under the terms of the above group policy and I authorize the deduction from my excess contribution reserve of the required contribution, if any, toward the cost of the insurance.

Further, I authorize the use of my Social Insurance Number for tax reporting, identification, and in the administration of my benefits.

I designate and appoint the above named beneficiary(ies) to receive any benefits payable under the Group Insurance Policy in the event of my death. I reserve the right to alter or revoke my designation of beneficiary in accordance with the terms of the Group Insurance Policy. I have read and understood the above.

_____ X_____
Date ***Member's Name (printed) & Signature***

_____ *X*_____
Date ***Witness's Name (printed) & Signature***

Member Benefits Trust

EXCESS CONTRIBUTION RESERVE – BENEFICIARY DESIGNATION

PERSONAL DETAILS:

UBCP #:_____

Mr. Mrs. Ms. Miss Male Female SIN.: _____ Prov/State of Residence:_____

Legal Name: _____ Stage Name:_____
Last First Middle (If applicable)

I DESIGNATE:

Last Name	First Name	Middle	Percentage (%)	Date of Birth (MM/DD/YYYY)	Sex	Relationship
		Total:	**100%**			

TRUSTEE DURING MINORITY CLAUSE: (The following must be completed if any primary beneficiary is a minor)

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(Full legal name) (Relationship to you)
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(Full legal name) (Relationship to you)
*to any minor child designated as a contingent beneficiary until such child's majority (based on the Province/State where they reside) and any payment so made to the said Trustee shall discharge the **Member Benefits Trust** (MBT) to the extent of such payment."*

_____ X_____
Date *Member's Name (printed) & Signature*

_____ *X*_____
Date *Witness's Name (printed) & Signature*