



# ROOFERS LOCAL 30 WELFARE PLAN

## Coordination of Benefits Application Form

If you have eligible Dependents listed on your Member Information Card, you must provide the Plan Administrator with the following additional information.

|                                                                                                                                                                                                                            |                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>1. Member Information</b>                                                                                                                                                                                               |                                                                                   |
| Last Name: _____ First / Middle Names: _____                                                                                                                                                                               |                                                                                   |
| Social Insurance Number: _____ Date of Birth: _____<br>MM / DD / YY                                                                                                                                                        |                                                                                   |
| Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> |                                                                                   |
| <b>2. Spouse's Information</b>                                                                                                                                                                                             |                                                                                   |
| Last Name: _____ First / Middle Names: _____                                                                                                                                                                               |                                                                                   |
| Date of Birth: _____<br>MM / DD / YY                                                                                                                                                                                       |                                                                                   |
| <input type="checkbox"/> My Spouse Is Not Employed And Does Not Have Any Coverage Under Any Benefits Plan                                                                                                                  |                                                                                   |
| <input type="checkbox"/> My Spouse Is Employed, But Does Not Have Any Coverage Under Any Other Benefits Plan                                                                                                               |                                                                                   |
| <input type="checkbox"/> My Spouse Is Employed and Has Coverage Under a Benefits Plan as Indicated Below:                                                                                                                  |                                                                                   |
| <input type="checkbox"/> Prescription Drugs:                                                                                                                                                                               | Family Coverage <input type="checkbox"/> Single Coverage <input type="checkbox"/> |
| <input type="checkbox"/> Vision Care:                                                                                                                                                                                      | Family Coverage <input type="checkbox"/> Single Coverage <input type="checkbox"/> |
| <input type="checkbox"/> Major Medical Health Care:                                                                                                                                                                        | Family Coverage <input type="checkbox"/> Single Coverage <input type="checkbox"/> |
| <input type="checkbox"/> Dental:                                                                                                                                                                                           | Family Coverage <input type="checkbox"/> Single Coverage <input type="checkbox"/> |
| Employer: _____                                                                                                                                                                                                            |                                                                                   |
| Insurance Company: _____ Policy Number: _____                                                                                                                                                                              |                                                                                   |
| Coverage Effective Date: _____ Coverage Termination Date: _____<br>MM / DD / YY MM / DD / YY                                                                                                                               |                                                                                   |

I certify that the information in this form is true and complete. I understand and agree that this coverage and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.

Plan Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Benefit Plan Services, 2255 Sheppard Ave. E, Atria 1, Suite 201, Toronto, ON M2J 4Y1  
Telephone: (905) 946-9700 • Toll Free: 1-800-263-3564 • Fax: (905) 946-2535

**Privacy Statement:** The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal Information will be protected pursuant to the relevant privacy legislation. The Plan may use and exchange information with third parties or organizations ( health professionals, institutions, investigative agencies, insurers, re-insurers, regulators, legal counsel) in order to manage the Plan and entitlement to the Benefits of the Plan.