UFCW LOCAL 401- REAL CANADIAN SUPERSTORE BENEFIT PLAN OVER-AGE DEPENDANT DECLARATION

SOCIA	L INSURANCE NUMBER	LAST NAME (Please Print)	FIRST NAME (Please Print) INITIAL
	- - - -			
DEPEND	ENT'S LAST AND FIRST NAME	GENDER DATE OF BIRTH ☐ Female YEAR MTH DAY ☐ Male	DEPENDENT'S LAST AND FIRST NAME	GENDER DATE OF BIRTH □ Female YEAR MTH DAY □ Male
DECLAF I declare	RATION that the above named depen	dent as defined below is:		
	Is unmarried;			
	Is not employed on a full-time basis;			
	Is not eligible for insurance as a Member under this or any other group policy;			
	Is either under 19 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.			
Please	provide proof of enrollme	ent in an accredited school, college o	or university.	
		(OR	
	Is unmarried and over the dependent age but fully dependent on me due to mental or physical disability.			
Please	provide proof that the ch	ild is not capable of self-support due	e to the disability.	
persona as long Howeve true, cor my iden	I information, noted on this as my personal information, I realize that such revoca rect, and complete, to the tity in the administration of	card, and coordinate my records with the on is needed to fulfill my benefit entitle ation may impair or cancel my participation best of my knowledge and belief. I auth	or of the Plan to collect, record, use, disclosions of the employers and participating union ements, or until I revoke it in a manner that on in the Plan. Furthermore, I certify that the lorize the use of my Social Insurance Numbing of any related tax matters. I understand to purposes.	ns. This authorization will survive at does not contravene the law. information, given in this card, is er as an additional verification of
Date:	N	1ember's Name:	Member's Signature:	

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