IBEW LOCAL 353
Pension & Benefit Plans

Change/Update of Information Form

This is a two-page form. Please complete the Member Information box and only the section(s) that apply based on the "Type of Change." Sign, date, and return the form to TEIBAS for processing (mail, fax, or scan and email). If you have any questions, or need any assistance in completing this form, please contact TEIBAS at 416-637-6789.

Type of Change: ☐ 1. Address ☐ 2. New Spouse ☐ 3. Remove Spouse ☐ 4. Member Name Change ☐ 5. Update Child Information

Member Information *(please print clearly in ink)* – *Required*

Social Insurance Number (SIN)	PIN – 10-digit number found on drug card	
Last Name	First Name	Middle Initial(s)

1. Address Change

Apartment No.	Address	
City	Province	Postal Code
Home Phone	Alternate Phone	Email Address

2. Add New Spouse

Under the **Local 353 Benefit Plan**, your "spouse" is the person you are legally married to and are currently living with in a conjugal relationship; or the person who is publicly presented as your spouse, who you are currently living with in a conjugal relationship and have been for at least the past 12 months. If you get separated or divorced, that spouse is no longer eligible for coverage – even if he or she continues to live with you.

Under the **Local 353 Pension Plan**, your "spouse" is the person with whom you are living at the time of your death who is: (a) married to you, or (b) not married to you and has been living with you in a conjugal relationship for at least three years, or (c) not married to you but living with you in a relationship of some permanence if you are the parents of your own or an adopted child as defined in the Family Law Act.

Last Name	First Name	Middle Initial(s)	Date of Birth (DD/MM/YYYY)

☐ Married (submit a copy of your marriage certificate)	☐ Common-Law (submit proof of living together at same address, dated one year ago, including a copy of your lease or mortgage, utility bills or tax returns)
Date of Marriage (DD/MM/YYYY)	Date of Cohabitation (DD/MM/YYYY)

Does your spouse have group benefit coverage with another plan? ☐ Yes ☐ No IF **YES**, DO THE BENEFITS INCLUDE:	BENEFIT	NO COVERAGE	SINGLE COVERAGE	FAMILY COVERAGE
	Healthcare	☐	☐	☐
	Dental	☐	☐	☐
	Vision	☐	☐	☐
	Drugs	☐	☐	☐

3. Remove Spouse *(provide separation agreement, divorce order, or death benefit certificate)*

☐ Divorced ☐ Separated ☐ Widowed

Last Name	First Name	Middle Initial(s)	Date of Birth (DD/MM/YYYY)

To continue, please see next page →

4. Member Name Change *(submit a copy of Legal Change of Name Certificate or driver's license)*

Last Name	First Name	Middle Initial(s)

5. Child Information *(if you have more than six children, please attach a separate sheet with this form)*

The plan covers your own or your spouse's natural, adopted, stepchildren and legal wards who are unmarried and dependent on you, and either: (a) under age 21, or (b) under age 25 and studying full-time at an approved post-secondary institution, or (c) covered under the plan continuously since the day before reaching age 21 and disabled.

Please submit a photocopy of the birth certificate, health card or adoption documentation.

ADD	CHANGE	DELETE	LAST NAME	FIRST NAME	MIDDLE INITIAL(S)	DATE OF BIRTH (DD/MM/YYYY)	GENDER (M/F)	IF 21 OR OLDER, CHECK ONE:	
								FULL-TIME POST-SECONDARY	DISABLED
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐
☐	☐	☐						☐	☐

I consent to the collection, use and disclosure of all information provided on this form for the purposes outlined in the TEIBAS Privacy Policy. I also certify that all of the information provided on this form, including information about my named beneficiary(ies), is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____ (DD/MM/YYYY)

NOTE: This is not a beneficiary form. To update your beneficiary(ies), please complete new beneficiary forms for your group life and accident insurance, pension plan, and RRSP (available at www.teibas.com or your IBEW Local 353 Union Hall).