teibas
TORONTO ELECTRICAL INDUSTRY BENEFIT ADMINISTRATION SERVICES

IBEW LOCAL 353 PENSION & BENEFIT PLANS

Change/Update Information Form

Mail, fax, or scan and email to TEIBAS. See contact information at end of this 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" you are making. Sign, date, and return the form to TEIBAS for processing. If you have any questions related to this form you can email us at members@teibas.com or call us at 416-637-6789 or toll-free at 1-800-267-0602.

TYPE OF CHANGE: (check all that apply)

1 ❍ Member Information	2 ❍ Address Change	3 ❍ Add Spouse	4 ❍ Remove Spouse	5 ❍ Name Change	6 ❍ Dependent

1. MEMBER INFORMATION: REQUIRED

Social Insurance No. (SIN): (optional) | PIN – 10-digit number on drug card:

Last Name: | First Name: | Middle Initial(s):

Apartment No.: | Address:

City: | Province: | Postal Code:

Home Phone: | Alternate Phone: | Email Address:

Date of Birth: (DD/MM/YYYY) | Gender: ❍ Male ❍ Female ❍ X | Marital Status: ❍ Single ❍ Married ❍ Common-Law ❍ Separated/Divorced

2. ADDRESS CHANGE / NEW ADDRESS

Apartment No.: | Address:

City: | Province: | Postal Code:

Home Phone: | Alternate Phone: | Email Address:

3. ADD SPOUSE

Under the IBEW 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 they continue to live with you.

Under the IBEW 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 but 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 biological or adoptive parents of dependant children 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 evidence of cohabitation of at least one year. Acceptable evidence includes a copy of a lease, mortgage, utility bill, tax return, CRA's Notice of Assessment, cohabitation agreement.) If there is no proof, please complete and submit a Declaration of Marital Status Form.

Date of Marriage: (DD/MM/YYYY) | Date of Cohabitation: (DD/MM/YYYY) | Gender: ❍ Male ❍ Female ❍ X

Does your spouse have benefit coverage with another plan? ❍ **YES** ❍ **NO**

Gender	Benefit	No Coverage	Single Coverage	Family Coverage
❍ Male ❍ Female ❍ X	Health Care	❍	❍	❍
❍ Male ❍ Female ❍ X	Dental	❍	❍	❍
❍ Male ❍ Female ❍ X	Vision	❍	❍	❍
❍ Male ❍ Female ❍ X	Drugs	❍	❍	❍

Page 1 of 2: to continue, please see next page →

Change/Update Information Form

4. REMOVE SPOUSE

(Submit a copy of the Separation Agreement, Divorce Order, or Death Certificate.)

❍ Divorced	❍ Separated	❍ Widowed	
Last Name:	First Name:	Date of Separation, Divorce or Death: (DD/MM/YYYY)	

5. NAME CHANGE - MEMBER / SPOUSE / DEPENDANT

(Submit a copy of Legal Change of Name Certificate or Driver's License.)

❍ Member	❍ Spouse	❍ Dependant	
Last Name:	First Name:	Date of Name Change: (DD/MM/YYYY)	

6. DEPENDANT INFORMATION

(If you have more than six dependants, 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 dependant on you, and who are 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 (incapable of self-sustaining employment by reason of mental or physical disability).

YOU MUST SUBMIT A PHOTOCOPY OF THE DEPENDANT'S BIRTH CERTIFICATE, HEALTH CARD, or ADOPTION DOCUMENTATION.

Add	Change	Delete	Last Name	First Name	Middle Initial(s)	Gender M/F/X	Date of Birth (DD/MM/YYYY)	21 or older, check one: Full-time Post-secondary	21 or older, check one: 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 spouse or dependant(s), 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 Group RRSP (available at www.teibas.com or the IBEW Local 353 Union Hall).

Privacy Warning: Please return your completed and signed forms to TEIBAS via mail or fax. If you wish to scan or provide your completed and signed form by email, please contact TEIBAS for assistance so that a secure encryption portal can be provided to you to safely return the form. Please be advised that if you return the form or provide any other sensitive or personal information to us by regular email, the information is not secure and may be vulnerable to unauthorized use. Neither TEIBAS nor the Board of Trustees of the Local 353, IBEW Trust Funds will be responsible for any unauthorized use, disclosure, interception or other privacy breach where personal information or other sensitive information is provided by you to TEIBAS through the use of email.

110 Sheppard Avenue East, Suite 705, Toronto, ON M2N 6Y8
T: 416-637-6789 | TF: 1-800-267-0602 | F: 416-637-6790
E: members@teibas.com | W: www.teibas.com | MP: www.myteibas.com