LiUNA LOCAL 837 HEALTH & WELFARE PLAN
170 JACKSON ST. EAST
HAMILTON, ON
L8N 1L4

MEMBER CERTIFICATE NUMBER
_____

THIS FORM MUST BE COMPLETED IN FULL BEFORE ANY CONSIDERATION OF PAYMENT FOR CLAIMS CAN BE MADE. (PLEASE PRINT CLEARLY)

MEMBER'S LAST NAME_____ FIRST NAME_____SEX_____

MEMBER'S SOCIAL INSURANCE NUMBER_____ MEMBER'S DATE OF BIRTH (MONTH) ____ (DAY) ____ (YEAR) ____

MEMBER'S ADDRESS: Number/Street/Apt./Unit _____

City _____ Province _____ Postal Code_____

Area Code & Phone Number (____)_____ E-MAIL ADDRESS _____

MARITAL STATUS: SINGLE _____ COMMON-LAW_____ LEGALLY MARRIED _____ DATE OF MARRIAGE _____

IF YOU ARE IN A COMMON-LAW RELATIONSHIP, HOW LONG HAVE YOU BEEN LIVING TOGETHER? MONTHS _____YEARS _____

SPOUSE'S LAST NAME_____ FIRST NAME_____ SEX _____

SPOUSE'S SOCIAL INSURANCE NUMBER_____ SPOUSE'S DATE OF BIRTH (MONTH) ____ (DAY) ____ (YEAR) ____

DOES YOUR SPOUSE HAVE OWN BENEFIT PLAN? (YES) ____ (NO) ____ EFFECTIVE DATE (MONTH) ____ (DAY) ____ (YEAR) ____

NAME OF SPOUSE'S INSURANCE COMPANY _____ POLICY & ID NUMBER _____

SPOUSE'S COVERAGE TYPE: SINGLE ____ FAMILY ____ SPOUSE COVERED FOR: HEALTH ____ DENTAL ____

IF YOUR SPOUSE'S BENEFITS HAVE TERMINATED, PLEASE INDICATE TERMINATION DATE: (MONTH) ____ (DAY) ____ (YEAR) _____

*****DEPENDENT CHILDREN – PLEASE LIST ALL DEPENDENT CHILDREN YOU WISH COVERED BELOW:**

LAST NAME	FIRST NAME	SEX	DATE OF BIRTH			RELATIONSHIP	SIN NUMBER for NEWBORNS ONLY
			MONTH	DAY	YEAR		

*****DEPENDENT CHILDREN AGED 21 TO 24 ATTENDING SCHOOL FULL-TIME MUST PROVIDE A CONFIRMATION LETTER FROM THE COLLEGE OR UNIVERSITY. THIS LETTER MUST BE UPDATED EACH NEW SCHOOL TERM.**
*****ALL NEWBORN CHILDREN UNDER THE AGE OF 1 REQUIRE A SOCIAL INSURANCE NUMBER. IF YOU DO NOT HAVE ONE, YOU MUST APPLY FOR ONE AND REPORT IT TO OUR OFFICE AS SOON AS POSSIBLE.**

MEMBER'S SIGNATURE: _____ DATE :_____

(REVISED August 2024)