COUGHLIN
employee benefits specialists
Coughlin & Associates Ltd.
P.O. Box 764
Winnipeg, MB R3C 2L4
Ph. (204) 942-4438 1-888-204-1234

IRON WORKERS (SASKATCHEWAN) L.U. 771 TRUST FUNDS

APPLICATION FOR DRUG CARD

Please print clearly and be sure to have Plan Member sign the form, in INK. *Sections 2 through 3 are to be completed by the plan member.*

1. Privacy

This section explains Coughlin & Associates Ltd.'s commitment to privacy.

Please read carefully.

Protecting Your Personal Information
As Administrator of your Group Benefit Plans, at Coughlin & Associates Ltd, we recognize and respect every individual's right to privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. The information is used to determine your eligibility for coverage and to administer the group benefits plan.

Why do we ask for your Social Insurance Number?
We ask for your SIN for:

- Income tax reporting purposes, to comply with the requirements under the Federal Income Tax Act, and
- Administrative purposes, such as ensuring the accuracy and integrity of your personal information by using your SIN as an internal identification number for you.

Use of name and address
From time to time, Coughlin & Associates Ltd. may use the address it has on file to provide you with additional information regarding the life insurance, benefits and/or pension coverage you are entitled to receive through your group benefits program. Your Consent allows Coughlin & Associates Ltd. to send additional information on these programs to you. Your name and address will not be used for any other purpose or disclosed to any other party, except where required by law. If you do not wish to receive such material, please contact Coughlin & Associates Ltd. at 204-942-4438 or, toll free, 1-888-204-1234 and your name and address will be removed from the contact list.

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

last name _____ given name(s) (in full) and middle initial _____

mailing address _____ city and province _____ postal code _____

telephone _____ email address _____

date of birth (day/month/year) _____ social insurance number _____

Gender

☐ Male ☐ Female

Marital Status

☐ Single ☐ Married
☐ Separated/Divorced ☐ Common-Law*
☐ Widowed

*Date of Marriage or Commencement of Common-Law Relationship

_____
day month year

3. Dependent Information

This section is to be completed by the plan member. **Please print clearly, in INK.** ***For purposes of coordination of benefits the Insurance industry has established parameters that require the need for the following information in order to coordinate coverages with your spouses carrier (if applicable).***

Spouse Information

last name _____ first name _____ middle initial _____

date of birth (day/month/year) _____

Gender

☐ Male ☐ Female

What group benefits coverage does your spouse have through an employer?

Healthcare → Does this include prescription drug coverage?

☐ Single ☐ Family ☐ Waived ☐ None ☐ Yes ☐ No

Dentalcare

☐ Single ☐ Family ☐ Waived ☐ None

Visioncare

☐ Single ☐ Family ☐ Waived ☐ None

Dependent Information
If there are more than three dependents, please attach a separate list.

last name	first name	middle initial	Date of Birth (day/month/year)	Relationship to Insured	Gender	Full Time Student	Disabled Dependent
					Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐
					Male ☐ Female ☐	Yes ☐ No ☐	Yes ☐ No ☐

I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature: _____ **Date:** _____

PLEASE RETURN TO COUGHLIN & ASSOCIATES LTD.