



U.A. LOCAL 71 HEALTH & WELFARE AND PENSION TRUST FUNDS

To: U.A. Local 71 Members applying for retirement benefits
Re: Member election form: Benefits following retirement

Part 1

Member information

NAME	
S.I.N.	PENSION START DATE (Y/M/D)

Part 2

Continuation of pension payments following my return to work for a participating employer

SUSPEND

- Please accept this as your authorization to suspend my pension payments should I return to work for a participating employer. Upon termination of employment, my pension payments will resume and will include credits for hours remitted to the pension plan during the period of re-employment. I understand that the suspended payments will be forfeited and I will not be entitled to a refund of the employer contributions made on my behalf under the collective agreement of which I am party.

OR

CONTINUE

- I waive my entitlement to any pension contributions and/or credits applicable to hours worked on or after my effective date of retirement. I request that my pension payments continue during any period of re-employment.

Part 3

Continuation of benefits under the U.A. Local 71 Health & Welfare Plan following retirement

My coverage under the U.A. Local 71 Health & Welfare Plan is currently in force. I understand that I may continue to participate in the plan following my retirement provided I have participated in the Health and Welfare Plan for the two years immediately preceding my effective date of retirement. As a retired member, all coverage will be provided to age 65 with the exception of the weekly indemnity and long-term disability benefits which I will no longer fund, or be eligible for, as of my effective date of retirement. At age 65, I will have the option to maintain extended health care and dental benefits, or just extended health care benefits on a self-pay basis. Should I continue to work beyond age 65, all coverage except extended health care and dental care benefits, will be terminated one month following the month in which 40 hours or less have been reported on my behalf.

- To maintain benefits as stated above, I understand that I am required to pay the applicable monthly premium. The premium for retired members under the age of 65 is currently \$290.37, plus applicable taxes. (Ontario residents add eight per cent RST and Quebec residents add nine per cent QST.) I may choose to have the monthly premium deducted from my monthly pension by completing the authorization form on the back of this form. A monthly benefit statement will be mailed to my home address.
- My coverage under the U.A. Local 71 Health & Welfare Plan is no longer in force or I do not have the required years of participation in the Plan. I understand that benefits may be reinstated following the accumulation of 280 hours with a participating employer prior to age 65.

Part 4

Authorization & Declaration

I **authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits and pension plan; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, I **confirm** that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorization & Declaration section is as valid as the original. I **certify** that the information given is true, correct and complete to the best of my knowledge.

Date _____ Signature _____
year / month / day

Note: Post-dated cheques payable to the U.A. Local 71 Benefit Trust Fund are required.

Protecting your personal information The administrator of your group benefits and pension plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits and pension plan. 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.



SEE OTHER SIDE →



U.A. Local 71 Pension Payment Deduction Options

Membership Dues and Retiree Health and Welfare Plan Premiums

A monthly payment is required from you to maintain your membership in the U.A. Local 71. A payment is also required for retiree coverage under the U.A. Local 71 Health and Welfare Plan. You may choose to have either or both of these monthly payments deducted automatically from your monthly pension payment.

Maintaining your membership in the U.A. Local 71 is a minimum requirement for retiree benefit coverage under the U.A. Local 71 Health and Welfare Plan, the International U.A. Burial Fund and any future pension increases.

If you do not wish either of these optional deductions, or if you are no longer a member in good standing of the U.A. Local 71, please disregard this form.

If you complete this form, please continue to make payments in the normal fashion until your new pension payment statement confirms the commencement of the applicable deduction. (The deductions will appear in the "Union Dues" and "Benefit Premiums" boxes on your new statement.)

I authorize Coughlin & Associates Ltd. on behalf of the U.A. Local 71 Health and Welfare Plan administration office to deduct from my monthly pension payment the amount required to maintain (please check all that apply):

A My monthly membership dues payable to the U.A. Local 71.

B The monthly premium required to maintain retiree coverage under the U.A. Local 71 Health and Welfare Plan.

The deduction(s) chosen above will commence the later of the next pension payment or the month for which membership dues/Health and Welfare Plan premiums are required (if you have already paid in advance).

This authorization remains in effect unless cancelled in writing by the undersigned.

Member's name (please print): _____

Member's Social Insurance Number: _____

Member's date of birth: _____

Member's signature: _____

Date signed: _____

Please return the completed form in the enclosed self-addressed envelope.

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