FORM 03

Dependant Information

(including Annual Over-Age Dependant Confirmation)

Please complete all information requested below, sign and return to Actra Fraternal Benefit Society (AFBS).

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416.967.6600 1.800.387.8897
FAX: 416.967.4744 1.888.804.8929
EMAIL: info@afbs.ca **WEB:** afbs.ca

AFBS WEST: 300 - 380 2nd Avenue West
Vancouver, BC V5Y 1C8
PHONE: 604.801.6550 1.866.801.6550
FAX: 604.801.6580
EMAIL: afbswest@afbs.ca **WEB:** afbs.ca

SECTION 1 – Member Information *(please print)*

Reset Form

Member Name (Last, First, Middle Initial)	Telephone Number	Date of Birth
		DD MM YYYY

Your AFBS Account Number	ACTRA/WGC Number (if applicable)
4501 ☐ ☐ ☐ ☐ ☐ ☐	

I participate in the following program (check one):

☐ AFBS Members' Insurance Program ☐ Employer Benefits Program ☐ Writers' Coalition Program ☐ Arts & Entertainment Plan®

☐ Other _____

ADDING DEPENDANTS

If you are under age 65, you have the option to insure your eligible dependants.

☐ I currently provide dependant coverage and I am adding a new dependant, as indicated in *SECTION 2*.

☐ I currently have benefits for myself only and would like to add my dependant(s) as indicated in *SECTION 2*. I understand that a six-month waiting period may apply. See Life Event below.

☐ I wish to insure my eligible dependant(s), as indicated in *SECTION 2*, who recently lost coverage elsewhere as indicated following:

Insurance Company	Group Policy #	Identification or Certificate #

Employer, Association or Organization Who Provided These Benefits	Date Benefits Terminated
	DD MM YYYY

Life Event: Benefits may begin immediately following a life event, when AFBS is notified within 45 days* of the occurrence. Benefits are effective from the first day of the month following notification, subject to the receipt of the applicable premium due. If AFBS is notified of a life event outside of the 45-day period following the occurrence, a six-month waiting period* will apply.

Examples of life events:
- Acquiring a spouse/partner
- Dependant(s) insured elsewhere lose access to similar benefits
- Birth or adoption of a child. Newborns are eligible for coverage on the date of hospital discharge or at 15 days of age, whichever occurs later.

Has a life event occured? YES ☐ NO ☐ (if 'NO' proceed to *SECTION 2*)

If 'YES' please specify the life event and date it occured on the line below, then proceed to *SECTION 2.*

_____ Date of Life Event DD MM YYYY

TERMINATING DEPENDANT COVERAGE

☐ The individual(s) indicated in *SECTION 2,* is/are no longer dependant(s) and should be removed from my AFBS coverage.

Please provide reason(s) for termination:

☐ Divorce or separation

☐ Attained coverage elsewhere

☐ Dependant is no longer eligible

☐ Other _____

If the removal of dependants results in your insurance providing benefits for only you, premium will be adjusted from the first day of the month, following receipt of your notification. When insured through the Members' Insurance Program, any premium credit will be returned to your Insurance Account.

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SECTION 2 – Dependant Information *(please print)*

Full Name of Dependant	Relationship	Date of Birth DD MM YYYY
Full Name of Dependant	Relationship	Date of Birth DD MM YYYY
Full Name of Dependant	Relationship	Date of Birth DD MM YYYY
Full Name of Dependant	Relationship	Date of Birth DD MM YYYY

FOR INSURANCE PURPOSES ONLY, **"DEPENDANTS"** ARE:

a) Your spouse/partner (legal or common-law) who is living with you. "Common-law partner" means a person who is publicly represented as being your spouse/partner and who has lived with you continuously for a minimum of two years (except where otherwise required by provincial legislation).

b) Any unmarried natural child, stepchild or legally adopted child or grandchild who lives with you and for whom you contribute the major amount of support, and who is:

(i) under 18 years of age

(ii) between the ages of 18 and 26 (coverage ceases on the dependant's 26th birthday) and attending a recognized college or university on a full-time basis (please complete Over-Age Dependant information below)

(iii) over 18 years of age who is incapable of self-sustaining employment due to a handicap or disability (Physician letter required)

SECTION 3 – Over-Age Dependant Information *(please print)* Annual reconfirmation is required.

Please provide information as appropriate based on the definition above:

Full Name of Over-Age Dependant	Name of College/University	Conclusion of Studies Date (if applicable) DD MM YYYY	Check if handicap or disability ☐
Full Name of Over-Age Dependant	Name of College/University	Conclusion of Studies Date (if applicable) DD MM YYYY	☐
Full Name of Over-Age Dependant	Name of College/University	Conclusion of Studies Date (if applicable) DD MM YYYY	☐

Consent

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that the purpose of providing this information to AFBS is to assist with the accurate administration of my Extended Health Care and dental benefits, as well as those of any insured dependants. I further understand that AFBS will provide this information to ClaimSecure, or successor provider of electronic claims processing, to assist with the adjudication of online claims submissions and claims processing and agree to this use of the information provided. I understand that I am responsible for advising AFBS within 45 days* of any change to this information and that failure to make such notification, in writing, may jeopardize my claims and those of my dependants.

I further certify that I am authorized to disclose and receive information about my spouse and any dependants for purposes of assessing and paying a benefit, if any, and that any reimbursement will be paid to me. A photocopy of this authorization is as valid as the original.

Member's Signature (required)	Date DD MM YYYY

AFBS is committed to protecting the confidentiality of the personal information we collect from you. We will use this information to revise your insurance benefits as indicated by you, and to assess the eligibility of Extended Health Care and dental claims submitted by you on behalf of your dependants under the program indicated.

* Employer Benefits Program participants - please refer to your Employee Handbook for the timeframes applicable to your program.