

# Plan Member Enrolment Form

All completed forms are to be signed and returned to Belmont Health & Wealth – Halifax Office:

33 Alderney Drive, Suite 700, Dartmouth, N.S. B2Y 2N4 for question or inquiries please reach out to [FFAW@gobelmont.ca](mailto:FFAW@gobelmont.ca) | 1-888-235-6169

PLAN MEMBER INFORMATION:							
Last Name		First Name		Initial	FFAW Membership ID -		
Email Address:		Occupation			Membership Expiry Date -		
Address							
City	Province	Postal Code	Telephone #				
Date of Birth MM   DD   YY	Gender	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/>	Date of Co-habitation (Common-law):		Effective Date of Coverage 07 01 2026		
SPOUSE INFORMATION:							
Last Name		First Name		Date of Birth MM   DD   YY		Gender	
DEPENDENT INFORMATION (LIST ADDITIONAL DEPENDENTS ON THE BACK OF THIS FORM):							
Last Name		First Name		Date of Birth MM   DD   YY	Gender		
1.							<input type="checkbox"/> Student <input type="checkbox"/> Disabled
2.							<input type="checkbox"/> Student <input type="checkbox"/> Disabled
3.							<input type="checkbox"/> Student <input type="checkbox"/> Disabled
COORDINATION OF BENEFITS: Do you or your dependents have health coverage under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No							
IF YES, COMPLETE THE FOLLOWING SECTION. BENEFITS WILL BE COORDINATED ACCORDING TO INDUSTRY STANDARDS.							
Other Plan covers: Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/>			Type of coverage: Health				
Primary Insured:		Name of Insurance Carrier:			Policy #:		
<b>BENEFICIARY DESIGNATION:</b> UNLESS OTHERWISE STATED, THE BENEFICIARY DESIGNATION BELOW WILL APPLY TO THE BASIC LIFE BENEFIT. IF A LEGAL BENEFICIARY IS NOT APPOINTED, BENEFITS ARE PAID TO THE ESTATE OF THE DECEASED MEMBER. FOR THE PROVINCE OF QUÉBEC, THE DESIGNATION OF YOUR SPOUSE AS BENEFICIARY IS PRESUMED IRREVOCABLE UNLESS OTHERWISE SPECIFIED; AND THE APPOINTMENT OF A TRUSTEE IS NOT AVAILABLE. PREVIOUS BENEFICIARY DESIGNATIONS IN RELATION TO MY COVERAGE ARE HEREBY REVOKED.							
Beneficiary's Last Name		First Name	Relationship	Date of Birth MM   DD   YY	Percentage (Must total 100%)	Revocable	Irrevocable
1.						<input type="checkbox"/>	<input type="checkbox"/>
2.						<input type="checkbox"/>	<input type="checkbox"/>
3.						<input type="checkbox"/>	<input type="checkbox"/>
If the designated beneficiary(ies) is(are) under the age of majority, please complete the Trustee appointment below;							
Trustee Name				Relationship		CONTACT INFORMATION	
PRIVACY INFORMATION / CONSENT:							
Personal information that we collect will be used for the purposes of administering the group benefits plan. I authorize Belmont Health & Wealth, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with Belmont Health & Wealth to exchange personal information when necessary for these purposes. I understand that I may revoke my consent at any time, however, doing so may prevent me from receiving the requested coverage or benefits.							
MEMBER AUTHORIZATION:							
I certify that the information given is true, correct and complete to the best of my knowledge. I understand that if any statement is incomplete or false, any coverage granted may be voided. I certify that I am a resident of Canada and covered under the provincial health care program. The authorization will remain valid for as long as I am claiming benefits or services, or until revoked by myself. I agree that a photocopy or electronic copy of this authorization is as valid as the original.							
MEMBER SIGNATURE: _____				DATE SIGNED: _____			

## Life and Health Insurance Coverage through the FFAW Association Plan

### Eligibility

All participants who are Canadian residents and members of the Fish, Food and Allied Workers (FFAW) Union are eligible for coverage on the effective date of the contract or at renewal. Members must be actively working on a full-time basis (including seasonal employment) on the date they would otherwise become eligible.

Coverage for all benefits terminates at member age 70.

### Coverage Details

#### Life Insurance

\$15,000

#### Health Insurance

##### Reimbursement Levels & Maximums:

- **Prescription Drugs:** 80% reimbursement, up to \$5,000 per contract year
- **Extended Health Care\*:** 80% reimbursement, up to \$5,000 per contract year
- **Paramedical Services\*\*:** 80% reimbursement, up to \$300 per practitioner per contract year
- **Vision Care:** 80% reimbursement, up to \$150 every 24 months
- **Virtual Health:** Access to Dialogue

\* Extended Health Care includes paramedical services, hospital accommodation, ambulance services, and a broad range of medical supplies.

\*\* Paramedical practitioners include psychologist, chiropractor, naturopath or homeopath, podiatrist or chiropodist, osteopath, massage therapist, acupuncturist, dietitian, physiotherapist, speech-language pathologist, and occupational therapist.

#### Dental Coverage

- Not included under this plan

### Payment Information

To activate and maintain coverage, the full annual premium must be paid in advance.

#### Payment Options:

- **Cheque:** Payable to Belmont Health & Wealth
- **E-Transfer:** FFAW@gobelmont.ca - please indicate members name in the EFT memo.

#### Annual Premium (including Virtual Health) for July 1st, 2026 - June 30th, 2027 Coverage.

- **\$2,504.17**

*Note: Premium is the same for single and family coverage.*

### Member Acknowledgement and Agreement

I acknowledge that by enrolling in this plan, I am committing to a full 12-month coverage period and understand that coverage is contingent upon payment of the full annual premium in advance.

I understand that there are no refunds of premium once coverage has been placed, including in the event of early termination or changes in eligibility.

I agree to notify Belmont Health & Wealth of any changes to my dependent status (including but not limited to marriage, separation, birth, or loss of coverage) within 30 days of the life event. I understand that changes submitted after this period may not be accepted.

I further acknowledge that continued participation in the plan is subject to annual re-enrollment requirements.

By signing below, I confirm that I have read, understood, and agree to the terms outlined above.

Member Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Belmont Health & Wealth  
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