

LiUNA!care

LOCAL 183™

BUILDING HEALTHY FUTURES

RETIREE APPLICATION PACKAGE

Retiree Division

Members Benefit Fund



Local 183 Members Benefit Fund - Retiree Division - Application Package

To qualify for the LiUNA Local 183 Members Benefit Fund - Retiree Division benefit plan, you must meet the following eligibility provisions.


Eligibility Requirements

- Member must be 55 years of age or older at the date of retirement.
- Member must be in good standing with LiUNA Local 183 for a minimum of 5 consecutive years immediately prior to your date of retirements and maintain a member in good standing status.
- Member must be collecting a pension with LiUNA Local 183 or Bricklayers Local 1 at the date of retirement. Industrial Division members must be retired and receiving a pension from the Canada Pension Plan.
- Member must be insured under a Provincial Health Insurance Plan at the date of retirement.
- Must apply for coverage within 45 days of retirement.
- Members with 50+ years (Gold Card) of continuous Local 183 Union membership will be eligible for benefit coverage on a complementary basis.
- Members must apply on the first day of the next month you cease to be eligible as an active member of LiUNA Local 183 Members Benefit Fund – Construction Division or Industrial Division, provided you remit the required monthly contributions on an interrupted basis.

Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Member to complete, date, and sign the Retiree Benefit Application Form.
3. Member to complete, date, and sign the Payor's Pre-Authorized Debit (PAD) Agreement.
4. Member to fully complete, date, and sign the Local 183 Members Benefit Fund – Retiree Division Application Card.
5. Enclose a void cheque from your bank account for pre-authorized automatic withdrawals of \$40.00 on the 15th of each month.
6. Enclose a photocopy of your Pension Certificate.
7. Enclose a photocopy of your up-to-date LiUNA Local 183 Union Dues proof of payment.
8. Return the completed application to LiUNAcare Local 183 by:

 Mail: **200 Labourers Way, Suite 2100 | Vaughan, ON | L4H 5H9**

 Questions: Email or call us at **416-240-7487** or **1-888-790-3534**

 Email: **info@liunacare183.com**

9. Keep a copy of the completed application for your records to substantiate your claim.

JANUARY 1, 2026

RETIREE LIFE INSURANCE	\$25,000
SPOUSAL LIFE INSURANCE	\$10,000
HEALTH CARE INSURANCE Lifetime Maximum Prescription Drugs Ontario Drug Benefit Deductible Nursing Care/Ambulance Durable Medical Equipment Physiotherapist* Chiropractor Speech Therapist* (Dependent Child Only) Clinical Psychologist / Psychotherapist Podiatrist/Chiropracist/Acupuncture/ Massage Therapy*/Osteopath/Naturopath/ Occupational Therapist/Athletic Therapist Orthopaedic Shoes (<i>custom made</i>) Orthotics (<i>custom made</i>) Hearing Aids Vision Care Contact Lenses Laser Eye Surgery	Unlimited 100% Rx drugs prescribed by a Physician and dispensed by a Pharmacist \$100 Yes Yes \$100 1 st visit / \$90 subsequent visits / \$2,000 per year combined \$100 1 st visit / \$85 subsequent visits / \$2,000 per year combined \$200 per visit / lifetime maximum of \$10,000 per dependent child \$105 per visit / max of \$2,000 per calendar year combined \$85 per visit / max of \$2,000 per calendar year combined 1 pair every 24 months to an overall maximum of \$500 50% reimbursement (1 pair) up to \$250 per calendar year max. \$3,500 every 36 months, one set / Batteries and Repairs included \$450 lenses / frames every 24 months / additional \$100 for lenses within same 24 months if as a result of a prescription change or damage to lenses Eye exam inclusive in the \$450 Vision Care Maximum Contact Lenses in lieu of glasses \$2,000 / Once in a Lifetime
DENTAL CARE Calendar Year Maximums Implants Routine, Full/Partial Dentures, Crowns, & Bridgework Dental Fee Guide	\$3,000 Calendar Year Maximum (per dependent) \$7,500 once every 5 years (excluding other dental) 100% 2026 O.D.A. Fee Guide Reimbursement
EMERGENCY TRAVEL ASSISTANCE - OUT OF PROVINCE BENEFIT Retiree / Spouse / Dependent	24 Hour Coverage \$5,000,000 per trip / up to age 80 \$2,500,000 per trip / between age 80 up to age 99 90 consecutive days per trip
LONG TERM CARE BENEFIT Retiree / Spouse	\$50 per day for Long Term Care services \$100 per day for eligible Home Care services Lifetime maximum benefit of \$300,000 per person
HOSPITAL CASH BENEFIT Retiree / Spouse / Dependent	\$200 per day for a minimum of three (3) days of hospitalization up to a maximum of 120 days
GROUP LEGAL SERVICES Retiree / Spouse	Wills, Power of Attorney, Real Estate, Separation Agreements, Cohabitation Agreement, Divorce, Highway Traffic Act <i>*Subject to the limitations as set out under the Group Legal Benefit Trust</i>
ADDITIONAL BENEFITS Retiree / Spouse / Dependent	Healthcare Navigation / Second Opinion Medical Advice / Expedited Healthcare / Mental Health - Inpatient, Outpatient, Video Therapy / Virtual Healthcare / Cancer Assistance Program / Self Help Works Program / Health Coaching Program / Virtual Home Delivery Pharmacy / Member Family Assistance Program / SMART Program / Canadian Addiction Treatment Centre / Financial Wellness / Parenting & Elder Caregiving / Health Assessment Centre / Child Disability Benefit

* Requires a MD Referral

A. Member Information (Please Print)

Last name	First Name	Gender	Male	Female
Address		Date of Birth (yyyy/mm/dd)		
Town/ City	Prov.	Postal Code	Date of Retirement	
Member Advantage Benefit Card ID Number (last 10 digits)		Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID		
Email Address		Phone #		
Marital Status	Married Common Law	Single Separated	Divorced Widow	Cell #

B. Dependent Information

In the boxes below, please list the relationship status, name and birth of all individuals

Name of Dependent	Relationship to Member (spouse, child etc.)	Birth Date			Address
		Day	Month	Year	

C. Dental Care Selection

Please select your current Dental Care Coverage:
 (Check one)

Outside Dental Care

LiUNA local 183 Dental Clinic

Note: If you are not currently registered with the LiUNA Local 183 Dental Clinic and would like to be, please refer to the *Dental Application / Withdrawal Form*.

D. Disclosure Member Authorization

Member Signature: _____ Date: _____
 Witness Signature: _____ Date: _____

OFFICE USE ONLY

Number of years with L.I.U.N.A. Local 183: _____ Union Dues up to date : _____
 Approved (start month of benefits active): _____ New Retiree (or coming from plan): _____
 Administrator Signature: _____ Date: _____

TERMS AND CONDITIONS

1. I/We hereby authorize Payee, in accordance with the terms of my/our account agreement with Processing Institution, to debit or cause to be debited the Account for the purposes indicated in the "Payment Type" section on page 1 of this agreement.
2. Particulars of the account that Payee is authorized to debit are indicated in the "Payment Details" section on page 1 of this agreement. A specimen cheque, if available for the Account, has been marked "VOID" and attached to this agreement.
3. I/We undertake to inform the Payee, in writing, of any change in the Account information provided in this agreement prior to the next due date of the PAD.
4. This agreement is continuing but may be cancelled at any time upon notice being provided by me/us, either in writing or orally, with proper authorization to verify my/our identity within the specified number of days before the next PAS is to be issued as noted on Cancel Payment section, Page 1. I/we acknowledge that I/we can obtain a sample cancellation form or further information on my/our right to cancel this agreement from the Processing Institution or by visiting www.cdnpay.ca. I/we acknowledge that if I/we wish to cancel this agreement or if I/we have any questions or need further information with respect to a PAD. I/we can contact the Payee at the telephone number or address set out in this agreement.
5. Revocation of this agreement does not terminate any contract for goods or services that exists between me/us and the Payee. This agreement applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
6. I/we acknowledge that provision and delivery of this agreement to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of this agreement to the Payee constitutes delivery by the Payor.
7. If this agreement is for fixed or variable amount business, personal or funds transfer PADs recurring at set intervals, unless I/we have waived any and all requirements for pre-notification of debiting in the "Waiver of Pre-notification" section on page 1 of this agreement, or unless the change in the amount of any such PAD will occur as a result of my/our direct action (such as, but not limited to, telephone instructions or other remote measures), I/we acknowledge I/we will receive:
 - a. with respect to fixed amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of the first PAD, and such notice will be received every time there is a change in the amount or the payment date(s)
 - b. with respect to variable amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of every PAD; or
 - c. with respect to business, personal or funds transfer PADs, at least 10 calendar days written notice from the Payee of any change in the amount of the PAD which results from a change in any applicable tax rate, a top-up or other adjustment. No pre-notification will be given if the amount of the PAD decreases as a result of a reduction in municipal, provincial or federal tax.Pre-notification may be given in writing or in any form of representing or reproducing words in visible form, which, if I/we have provided an email address to the Payee, includes an electronic document. The amount of pre-notification provided will change when there is a change in the pre-notification requirements contained in the CPA rules.
8. If this agreement provides for PADs with sporadic frequency, I/we understand that the Payee is required to obtain an authorization from me/us for each and every PAD prior to the PAD being exchanged and cleared. I/we agree that a password or security code or other signature equivalent will be issued and will constitute valid authorization for the Processing Institution to debit the Account.
9. I/we acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of this agreement, including, but not limited to, the amount.
10. I/we acknowledge that the Processing Institution is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by Payee as a condition to honoring a PAD issued or caused to be issued by Payee on that Account.
11. I/we acknowledge that, if this agreement is for personal or business PADs or for funds transfer PADs that have recourse through the clearing system, a PAD may be disputed under the following conditions:
 - a. The PAD was not drawn in accordance with this agreement;
 - b. This agreement was revoked; or
 - c. Pre-notification was required and was not receivedI/we further acknowledge that in order to be reimbursed, a declaration to the effect that either a, b, or c took place must be completed and presented to the branch of the Processing Institution holding the Account on or before the 90th calendar day in the case of a personal PAD or a funds transfer PAD that has recourse through the clearing system or, in the case of a business PAD, on or before the 10th business day, in each case after the date on which the PAD in dispute was posted to the Account.
12. I/we acknowledge that any claim made after the periods set out above must be resolved solely between me/us and the Payee and there is no entitlement to reimbursement from the Processing Institution.
13. I/we acknowledge and agree that if this agreement is for funds transfer PADs and the Payee does not provide recourse through the clearing system, then no recourse will be provided through the clearing system (that is, I/we will not receive automatic reimbursement in the event of a dispute) and I/we must seek reimbursement or recourse from the Payee in the event a PAD is erroneously charged to the Account.
14. Unless this agreement is for a funds transfer PAD that does not have recourse through the clearing system, I/we acknowledge that I/we have certain recourse rights if a debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my/our recourse rights I/we can contact my/our Financial Institution or visit www.cdnpay.ca.
15. I acknowledge that I/we understand that I/we am/are participating in a PAD plan established by the Payee and I/we accept participation in the PAD plan upon the terms and conditions set out herein.
16. I/we consent to the disclosure of any personal information that may be contained in this agreement to the financial institution that holds the account of the Payee to be credited with the PAD to the extent that such disclosure of personal information is directly related to and necessary for the proper application of Rule H1 of the Rules of the Canadian Payments Association.

ATTACH VOID CHEQUE HERE

This section is to be completed by the plan member. Please print clearly in ink. Corrections must be clearly crossed out and initialed (no white-out).

1 Member Information - Must be completed in full

Last Name:		First Name:		Middle Name:
Address:		City:	Province:	Postal Code:
Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Married: <input type="checkbox"/> Common Law: <input type="checkbox"/> Single: <input type="checkbox"/>	Date of Marriage/Cohabitation: MM / DD / YY		Date of Birth: MM / DD / YYYY
Home Phone #:	Cell #:	Email:		
Does your spouse have any other benefits provided under any group insurance? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		Insurance Agency:	Policy #:	
Preferred Language:		Preferred Method of Contact : Letter: <input type="checkbox"/> Email: <input type="checkbox"/> Phone: <input type="checkbox"/>		

2 Dependent Information (Spouse) - Must be completed in full, if applicable.

This section is to be completed by the plan member. If you wish to cover your eligible dependents, please list your dependents by completing the following section. Corrections must be clearly crossed out and initialed (no white-out).

Last Name:	First Name:	Middle Initial:	Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Date of Birth: MM / DD / YYYY
What group benefits does your spouse have through their employer? Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.				
Married: <input type="checkbox"/> Common Law: <input type="checkbox"/>	Health Care: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Vision Care: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Dental Care: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	

2 Dependent Children - Must be completed in full, if applicable.

Last Name	First Name	Middle Initial	Date of Birth	Sex	Full Time Student	Disabled Dependent	Member Relationship
			MM / DD / YYYY				
			MM / DD / YYYY				
			MM / DD / YYYY				
			MM / DD / YYYY				

3 Group Life Insurance Beneficiary - Must be completed in full

This section must be completed to designate a beneficiary for your life benefits. The original of this form will be required for a life claim. Corrections must be clearly crossed out and initialed (no white-out).

Full Legal Name (Last Name, First Name)	Date of Birth	Address	Phone #	% Allocated	Member Relationship
	MM / DD / YYYY				
	MM / DD / YYYY				
	MM / DD / YYYY				

4 Member Signature

Signature: _____ Date: MM / DD / YYYY

DEPENDENTS

A dependent spouse or common law to be eligible as your dependent must be residing at the same address as the member for a period of 1 year or more to qualify for benefits or joined by virtue of a valid civil or religious ceremony.

Dependent children must be age 20 years of age or younger (children from 21 years of age but under age 25) will be covered provided they are attending an accredited school, college, or university as a full time student provided annual proof of student registration is submitted.

COLLECTION OF PERSONAL INFORMATION

Benefit Plan Administrators Limited (BPA) on behalf of the Trust Fund collects personal information from you, your employer or your former employer, and your union local, to determine your eligibility and benefit entitlements under your plan. Your employment history may be shared with your union for the purpose of monitoring the contributions required to be made under the terms of the Collective Agreement. Your personal information is kept confidential and safeguarded. BPA will only release relevant personal information to your eligible dependents specific to their benefit entitlements. Your personal information (and the personal information of your dependents) may be disclosed to insurance carriers, auditors and other benefit providers so that they can perform services in connection with the administration on the Plan. Disclosure will be limited to the specific information required for a particular purpose. Personal information may also be disclosed as required or permitted by law. I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above. I hereby apply for participation in the Trust Fund. I appoint the following beneficiary with respect to any Group Life Insurance proceeds to which designated beneficiary may become entitled and I reserve the right to change the beneficiary from time to time, subject always to the provisions of any law or government regulations governing designation of beneficiaries in force from time to time. If the named beneficiary predeceases me and no other has been appointed, such proceeds shall be payable to my Estate.

L183MBFR 2026-01

Please complete all sections in detail and sign Section 4 of this application with pen. Any benefits to which you may be entitled under your Benefit Plan may not be paid until this card is completed, dated, signed and filed with the Plan Administrator. A new card is required to change any information. Corrections must be clearly crossed out and initialed (no white-out).

Please Return Original Application Card
via mail or email to:
LIUNAcare Local 183
2100 - 200 Labourers Way
Vaughan, ON L4H 5H9

Contact Us:
Phone: 416-240-7480
Member Services: 416-240-7487
Email: info@liunacare183.com