LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

Labourers' Local 183
Retiree Benefit Trust Fund

RETIREE APPLICATION PACKAGE

LABOURERS' LOCAL 183
RETIREE BENEFIT TRUST FUND

APPLICATION PACKAGE

SUBMISSION INSTRUCTIONS:

- Member to complete and sign Retiree Benefit Application Form.
- Member to complete and sign Payor's Pre-Authorized Debit (PAD) Agreement.
- Member to complete and sign Retiree Application Card.
- Enclose a void cheque for direct account withdrawals.
- Enclose a copy of Pension Certificate.
- Enclose proof of up to date Local 183 Union Due payments.
- Send completed application package to:

LiUNAcare Local 183
2100 - 200 Labourers Way
Vaughan, ON L4H 5H9

Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
Email: info@liunacare183.com

LiUNA! care
LOCAL 183
BUILDING HEALTHY FUTURES

Retiree Benefit Plan Application
Eligibility Requirements/Document Checklist

To qualify for the Labourer's Local 183 Retiree Benefit Trust Fund Benefits Plan, you must meet the following eligibility provisions:

- 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 retirement 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 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 or Labourers' Local 183 Industrial Benefit Fund, provided you remit the required monthly contributions, on an uninterrupted basis.

If you have met the eligibility requirements indicated above, please provide the following documentation:

- ☐ Enclosed Retiree Benefit Application Form **completed, dated and signed**;
- ☐ Enclosed Payor's Pre-Authorized Debit (PAD) Agreement Form **completed, dated and signed**;
- ☐ Enclosed Local 183 Retiree Benefit Trust Fund Application Card **fully completed, dated and signed**;
- ☐ A photocopy of your Pension Certificate;
- ☐ A photocopy of your LiUNA Local 183 union dues proof payment;
- ☐ A void cheque from your bank account for pre-authorized automatic withdrawals of $45.00 on the 15th of each month.

LiUNA!care LOCAL 183
BUILDING HEALTHY FUTURES

RETIREE BENEFITS SUMMARY
September 1, 2024

RETIREE LIFE INSURANCE	$25,000
SPOUSAL LIFE INSURANCE	$10,000
HEALTH CARE INSURANCE	
Lifetime Maximum	Unlimited
Prescription Drugs	100% Rx drugs prescribed by a Physician and dispensed by a Pharmacist
Ontario Drug Benefit Deductible	$100
Nursing Care/Ambulance	Yes
Durable Medical Equipment	Yes
Physiotherapist*	$100 1st visit / $90 subsequent visits / $2,000 per year combined
Chiropractor	$100 1st visit / $85 subsequent visits / $2,000 per year combined
Speech Therapist* (Dependent Child Only)	$200 per visit / lifetime maximum of $10,000 per dependent child
Clinical Psychologist / Psychotherapist	$105 per visit / max of $2,000 per calendar year combined
Podiatrist/Chiropodist/Acupuncture/Massage Therapy*/Osteopath/Naturopath/Occupational Therapist/Athletic Therapist	$85 per visit / max of $2,000 per calendar year combined
Orthopaedic Shoes *(custom made)*	1 pair every 24 months to an overall maximum of $500
Orthotics *(custom made)*	50% reimbursement (1 pair) up to $250 per calendar year max.
Hearing Aids	$3,500 every 36 months, one set / Batteries and Repairs included
Vision Care	$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	Contact Lenses in lieu of glasses
Laser Eye Surgery	$2,000 / Once in a Lifetime
**** requires a MD referral***	
DENTAL CARE	
Calendar Year Maximums	$3,000 Calendar Year Maximum (per dependent)
Implants	$7,500 once every 5 years (excluding other dental)
Routine, Full/Partial Dentures, Crowns, & Bridgework	100%
Dental Fee Guide	2023 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 **Subject to the limitations as set out under the Group Legal Benefit Trust*
ADDITIONAL BENEFITS Retiree / Spouse / Dependent	Healthcare Navigation / Second Opinion Medical Advice / Expedited Healthcare / Mental Health / 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

LiUNA!care LOCAL 183
BUILDING HEALTHY FUTURES

RETIREE BENEFIT APPLICATION FORM

Send to: LiUNAcare Local 183 | 2100 - 200 Labourers Way | Vaughan, ON L4H 5H9
P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

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 Day	Month	Year	Address

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: _____

LiUNA! care
LOCAL 183
BUILDING HEALTHY FUTURES

PAYOR'S PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Send to: LiUNAcare Local 183 | 2100 - 200 Labourers Way | Vaughan, ON L4H 5H9
P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

A. Member Information *(Please Print)*

Last Name First Name		Gender ☐ Male ☐ Female
Address		Date of Birth (yyyy/mm/dd)
Town/ City Prov. Postal Code		Country
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. Instructions

1. The Payee must retain this agreement for at least 12 months after the last Pre-Authorized Debit (PAD) is issued.
2. The Payee can obtain the transaction type code from the CPA's website: http//www.cdnpay.ca/rules/pdfs_rules/standard_005.pdf Go to Section E, Appendix 2, "Transaction Types"
3. The Payee will insert the number of days required to "Cancel Payment" Section (cannot exceed 30 days)
4. Please see the Terms and Conditions on reverse.

☐ New Authorization ☐ Change to Existing Plan Expiry Date (m/d/y): _____

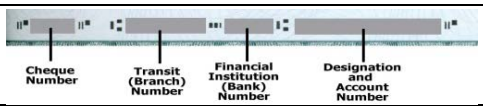
C. Payment Information *(Please Print)*

Description of PAD **Benefits**	CPA Transaction Type Code **330**	Amount of Payment	Dates:
Pavee Institution **20872**	Branch **828**	Account No. **1020155**	

C. Payor & Account Information (*Attach Void Cheque to Form)*

Please see example cheque on back for Transit, Bank and Account No.

Account Holder(s) Name:



Transit No:	Bank No:	Account No:

D. Waiver of Pre-Notification

I/We waive any and all requirements for pre-notification of debiting, including without limitation, pre-notification of any changes in the amount of the PAD due to change in any applicable rate, top up or adjustment.

E. Authorization

I/We Acknowledge that this agreement is provided for the Benefit of the "Payee" and "Processing Institution" and is provided in consideration of the Processing Instutition agreeing to process debits ("PAD") against the Account with the Processing Institution in accordance with the Rules of the Payments Association (the "CPA Rules").

By signing this agreement, the Payor acknowledges having received and having read a copy of this agreement, including the terms and conditions on acknowledges understanding the terms and conditions of this agreement, and agrees to bond by the terms and conditions of this agreement, including terms and conditions on reverse. I/We warrant and guarantee that the Person(s) whose signature(s) is/are required to sign on the Account have signed Agreement.

Note: If only one signature is required forthis account, then only one Payor is needed to sign. However is two or more signatures are required, the both or all payors *must* sign.

Payor Signature: _____ Payor (2) Signature: _____

Date: _____ 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.

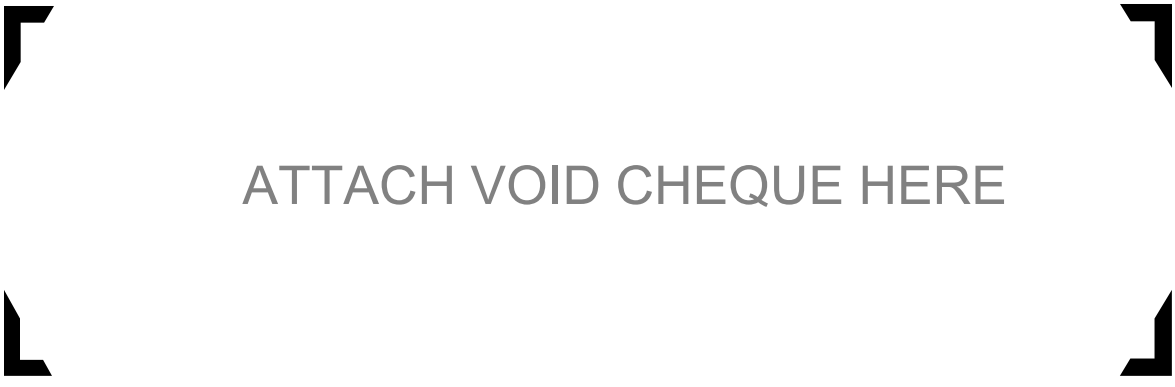
Pre-notification may be given in writing or in any form of representing or reproducing words in visible form, which, if I/we have provided an email address to the Payee, includes an electronic document. The amount of pre-notification provided will change when there is a change in the pre-notification 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 exchanges 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 received

I/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.



LiUNA! LOCAL 183 RETIREE BENEFIT TRUST FUND

Social Insurance Number	183 Union Number

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: ☐ Female: ☐ Married: ☐ Common Law: ☐ Single: ☐	Date of Marriage/Cohabitation: MM / DD / YYYY	Date of Birth: MM / DD / YYYY
Home Phone #:	Cell #:	Email:
Does your spouse have any other benefits provided under any group insurance? Yes: ☐ No: ☐	Insurance Agency:	Policy #:
Preferred Language:	Preferred Method of Contact : Letter: ☐ Email: ☐ Phone: ☐	

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: ☐ Female: ☐	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: ☐ Common Law: ☐	Health Care: Yes: ☐ No: ☐	Vision Care: Yes: ☐ No: ☐	Dental Care: Yes: ☐ No: ☐

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 (First/Middle Initial/Last)	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

CLEAR FORM

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 or monitoring the contributions required to be made under the terms or 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 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.

Please complete all sections in detail and sign Section 4 of this application. 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 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