NOTIFICATION OF CHANGE

UFCW/MAPLE LEAF FOODS INC. BENEFIT PLAN

3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

BEFORE SIGNING THIS FORM, YOU SHOULD UNDERSTAND THE MEANING OF THE FOLLOWING "EXPLANATION" AND THE "AUTHORIZATION" ON THE BACK OF THIS FORM. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE PLAN ADMINISTRATOR.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your dependents and beneficiaries. This information comes from this form, the reports your Employer submits to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Plan administrator, and, it is used to: communicate with you; determine coverage and benefit entitlement; satisfy the reporting requirements of the provincial and federal governments; pay taxes; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express permission, and will be kept confidential and secure. Also it is available for your review, by contacting the Plan administrator.

SOCIAL INSURANCE NUMBER	MEMBER'S FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME

PLEASE COMPLETE THE APPLICABLE SECTIONS ONLY

CHANGE IN MARITAL STATUS

☐ MARRIED: Maiden name _____ DATE OF MARRIAGE _____

☐ COMMON-LAW RELATIONSHIP: Date relationship commenced _____

☐ MARRIAGE / COMMON-LAW BREAKDOWN: Date you began living separate and apart _____

☐ WIDOWED: Date of death of spouse _____

ADDITIONAL DEPENDENTS

NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR	NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR

IF YOU ARE ADDING A SPOUSE, PLEASE ANSWER THESE QUESTIONS:

Does your Spouse have Prescription Drug coverage under another plan?

☐ No

☐ Yes (If Yes, name of Insurance Company, Policy Number and Effective Date of Coverage) _____

Is your Spouse employed at any Maple Leaf Plant? ☐ No ☐ Yes – Spouse's Name _____

DELETION OF DEPENDENTS

NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR	NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR

CHANGE IN MAILING ADDRESS

APT & STREET No.	STREET	CITY	PROVINCE	POSTAL CODE

CHANGE IN BENEFICIARY FOR LIFE INSURANCE

I do hereby designate and appoint the following beneficiary(ies) to receive any death benefit that may become payable under the Plan. I reserve the right to change my beneficiary(ies) from time to time, subject to complying with the applicable laws and regulations governing the designation of beneficiaries.

Last Name	First Name		Relationship	Birth Date	Percentage %
_____		my	_____	_____	_____
_____		my	_____	_____	_____
_____		my	_____	_____	_____

I understand that if I do not designate a beneficiary or if my designated beneficiary(ies) predecease(s) me and no others have been appointed, the death benefit, if any, shall be payable to my estate.

IF A DESIGNATED BENEFICIARY IS UNDER AGE 18 PLEASE COMPLETE THE FOLLOWING:

I hereby appoint _____ my _____ if living, as Trustee to receive and disburse any monies payable hereunder to the above named child(ren) during minority, and any payment so made to the said Trustee shall discharge the Plan to the extent of such payment.

Member Signature _____ Date _____

PLEASE TURN OVER FOR BANKING INFORMATION AND SIGNATURES OF AUTHORIZATION

DIRECT DEPOSIT FOR CLAIM PAYMENTS - BANKING INFORMATION

Bank Account Holder's Name (if different from Plan Member) _____

ATTACH A "VOID" CHEQUE TO THIS FORM, OR, HAVE YOUR FINANCIAL INSTITUTION COMPLETE THE FOLLOWING BANK ACCOUNT INFORMATION:

Name of Financial Institution		Address of Financial Institution
Branch (Transit) Number (5 digits)	Bank Number (3 digits)	Account Number (maximum 12 digits)

An electronic Explanation of Benefits (EOB) showing what has been paid will be emailed to you once your claim has been processed.

Email address: _____

AUTHORIZATION

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy the personal information noted on the reverse of this form. This authorization will survive as long as this information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purpose.

Furthermore, I certify that the information, given on this form, is true, correct and complete to the best of my knowledge and belief.

_____ _____

Signature of Member Date

Also, if you are adding a Spouse or Dependent Child age 18 or over please have them sign below.

_____

Signature of Spouse

_____

Signature of Dependent Child Age 18 or Over

_____

Signature of Dependent Child Age 18 or Over

_____

Date