

**AMERICAN FEDERATION OF MUSICIANS' AND EMPLOYERS'
PENSION WELFARE FUND (CANADA)
MEMBER INFORMATION/CHANGE OF BENEFICIARY CARD**

Last Name of Member (Legal Name)		First Name		Initial	
Professional Name:					
Address/Street Number & Name					Box No./Apt. No.
City, Town, Village			Province		Postal Code
Date of Birth	Month	Day	Year	Marital Status	
				<input type="checkbox"/> Single	<input type="checkbox"/> Separated
				<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Widowed	<input type="checkbox"/> Common-Law
Social Insurance No.			Sex		
			<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Spouse is a person to whom you are married or with whom you are living in a common-law relationship for a specific period of time			Date of marriage or commencement of co-habitation if currently living with spouse.		
			Month	Day	Year
Spouse's Last Name (if different)			Spouse's First Name		Spouse's Initial
Spouse's Social Insurance No.			Spouse's Date of Birth	Month	Day
					Year
NOTE:					
The definition of spouse varies by province. If you have an eligible spouse, pension legislation or the terms of this Plan or both may provide that your spouse has the right to any benefits payable on your death unless that right is waived. If you do not have an eligible spouse, please complete the following beneficiary information. If you do not wish to designate a beneficiary please indicate "Estate."					
Beneficiary's Last Name		Beneficiary's First Name		Beneficiary's Initial	
Beneficiary's Social Insurance No.		Beneficiary's Date of Birth		Beneficiary's Sex	
		Month	Day	Year	
Address of Beneficiary (if different from yours) /Street Number & Name					Box No./Apt. No.
City, Town, Village			Province		Postal Code
Relationship of Beneficiary			This Beneficiary Appointment Section must be signed and dated. Your signature must be witnessed by an adult other than your spouse or beneficiary.		

MEMBER DECLARATION

I hereby appoint as my beneficiary for Pension and other benefits resulting from my death for which I qualify under the named Plan the beneficiary named herein, reserving to myself the right to change or revoke such appointment notwithstanding acceptance thereof and subject to any legal restrictions, by written notice to the Administrator of the Plan.

I hereby authorize the use of the information contained on this form including my social insurance number, by the Board of Trustees, its agents and employees and by my Employer for the administration of my benefits.

Signature of Member

Date

Signature of Witness

Date
