Application for Membership in a Local Union

of the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists and Allied Crafts of the United States, its Territories and Canada

I hereby make application for membership in Local No. AQTIS 514 IATSE of the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists and Allied Crafts of the United States, its Territories and Canada ("the Union"). I base my application for membership on the following facts, which I affirm to be true:

THIS APPLICATION MUST BE ACTED UPON WITHIN SIX MONTHS OTHERWISE A NEW APPLICATION MUST BE SUBMITTED.

I, _____, was born on _____ and presently
(Print or Type Name) (Month) (Day) (Year)

reside at _____,
(Street) (City) (State/Province) (Zip/Postal Code)

Home Phone _____ Cell Phone _____

Email Address _____ Do you have a Twitter account? ☐ Yes ☐ No

My Social Security/Insurance Number is _____.

I am by occupation a _____ and have worked at the following employers in the

entertainment industry: _____

Presently employed by _____ as a _____
(Specify Occupation)

THIS APPLICATION MUST BE ACCOMPANIED BY THE $100.00 PROCESSING FEE OR $10.00 PROCESSING FEE FOR SPECIAL DEPARTMENT LOCAL UNIONS.

Previously applied for membership in a Local Union or Department of the I.A.T.S.E.? _____, to Local No. _____

Was Application rejected? _____. This application is for Journeyman X or Apprentice _____? (check one)

PLEDGE

I, the undersigned, as a condition of my membership in the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists and Allied Crafts of the United States, its Territories and Canada, do solemnly pledge myself to accept and abide by the provisions of the I.A.T.S.E. Constitution and Bylaws, as now in force and hereafter legally amended, hereby express my consent to be governed thereby in the conduct of my trade and in my relationship with the Union.

Signature of Applicant _____ Date _____, 20____

Initiation Fee 100$ Amount Paid 100$

(LOCAL SEAL HERE)

This application submitted by Local No. AQTIS 514 IATSE

Secretary Nicolas Marin

This is to certify that _____ has on this _____ day of _____, 20 ____, been admitted to membership in Local No. AQTIS 514 IATSE having fully complied with the requirements as set forth in the Constitution and Bylaws of the Local Union and the International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists and Allied Crafts of the United States, its Territories and Canada.

Member's Social Security/Insurance Number _____

(LOCAL SEAL HERE)

_____, President

Nicolas Marin
_____, Secretary

THIS STUB TO BE COMPLETED AND RETURNED TO THE GENERAL OFFICE IMMEDIATELY FOLLOWING APPLICANT'S ADMISSION TO MEMBERSHIP.

MEDAVIE BLUE CROSS™

GROUP BENEFITS APPLICATION

644 MAIN ST PO BOX 220
MONCTON NB E1C 8L3
TEL: 1-800-667-4511 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

230 BROWNLOW AVE DARTMOUTH
PO BOX 2200 HALIFAX NS B3J 3C6
TEL: 1-800-667-4511 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

PO BOX 2000, 185 THE WEST MALL SUITE 1200
ETOBICOKE ON M9C 5P1
TEL: 1-800-355-9133 FAX: 1-506-869-9653
maax.policy.administrators@medavie.bluecross.ca

1981 MCGILL COLLEGE AVENUE, SUITE 100
MONTREAL, QC H3A 3A7
TEL: 1-888-588-1212 FAX: 1-514-286-8444
administration@medavie.bluecross.ca

1. TO BE COMPLETED BY THE EMPLOYER

Name of Employer: _____

Policy Number: _____ Division Number: _____ Class: _____

Permanent Date Employed (DD/MM/YYYY): _____ Eligible Date of Coverage (DD/MM/YYYY): _____

Occupation/Job Title: _____

Employee Payroll Number (if applicable): _____ Province of Employment: _____

Number of hours worked per week: _____ Salary (before deductions): _____ Frequency: ❍ Annual ❍ Monthly ❍ Weekly ❍ Bi-Weekly ❍ Hourly

HCSA Allocation $ (if applicable): _____ PSA Allocation $ (if applicable): _____

Employment Type: ❍ Full Time Hourly ❍ Part Time Hourly ❍ Full Time Salary ❍ Part Time Salary ❍ Contract/Temporary

Employer Signature: _____ Date (DD/MM/YYYY): _____

2. EMPLOYEE AND FAMILY INFORMATION

Employee First Name: _____ Employee Last Name: _____

Gender: ❍ Male ❍ Female Language Preferred: ❍ English ❍ French Date of Birth (DD/MM/YYYY): _____

Address (Street & Number): _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Employee E-mail Address: _____

Health / Dental Coverage: ❍ Employee Only ❍ Employee & Spouse ❍ Employee & Family ❍ Single Parent

Spouse (if applicable)

First Name: _____ Last Name: _____

Gender ❍ Male ❍ Female Birth Date (DD/MM/YYYY): _____

Status: ❍ Married ❍ Common-Law Date of co-habitation if common-law (DD/MM/YYYY): _____

Dependent Children (if applicable)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Gender M/F	Dependent Status
			❍ Male ❍ Female	❍ Disabled ❍ Student - College/University
			❍ Male ❍ Female	❍ Disabled ❍ Student - College/University
			❍ Male ❍ Female	❍ Disabled ❍ Student - College/University

If eligible, the Dependent Life benefit will be provided automatically if the dependent information is provided within this section or Section 4 - Beneficiary.

OTHER COVERAGE (CO-ORDINATION OF BENEFITS)

Do you or any of your dependents have coverage under any other Plan? ❍ Yes ❍ No **If Yes, complete the following:**

Name of the Other Insurer: _____ Effective Date of Coverage (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____

Type of Coverage:
☐ **Health** - ❍ Single ❍ Family ❍ Single Parent ❍ Employee and Spouse
☐ **Dental** - ❍ Single ❍ Family ❍ Single Parent ❍ Employee and Spouse

3. WAIVER OF COVERAGE

All benefits under your group insurance plan are mandatory and provided to you based on the group contract. However, you may waive the health and dental benefits if you have similar coverage under your spouse/common-law partner's plan.

❍ I have been given the opportunity to apply for coverage but do not wish to participate. I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Medavie Blue Cross. Also, I may be required to submit medical evidence of insurability at that time.

❍ I understand that should I lose spousal coverage, and do not apply for coverage under this policy within 31 days of losing spouse/common-law partner's plan, I may be required to submit medical evidence of insurability to apply for coverage under this policy after the afore mentionned period of 31 days.

I do not want to participate in the following coverage: ❍ Health ❍ Dental ❍ Both Health and Dental

For Quebec Residents: Participation in the Health coverage plan can only be declined due to spousal coverage. If declining the Health coverage, please complete your spouse's coverage information.

4. BENEFICIARY

Any beneficiary(ies) designated below may be revocable or irrevocable at your choice.

- A revocable designation can be changed at any time by completing and submitting a new designation form;
- An irrevocable designation requires the written consent of the named irrevocable beneficiary in order to remove their name as beneficiary and/or change the allocation amount (%). The beneficiary must be of the age of majority under the provincial jurisdiction of residence to provide the written consent.

If the beneficiary designation is not specified, it will be considered revocable by default, with the exception of the Province of Quebec, the beneficiary designation of a spouse is irrevocable by default, unless revocable is specified below.

Benefits are paid to the designated beneficiary(ies) below. If a legal beneficiary has not been appointed and the below fields are left blank, benefits are paid to the estate of the deceased employee.

Primary Beneficiary(ies)

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship

Contingent Beneficiary(ies): The individual(s) designated by the Employee to receive benefits in the event the primary beneficiary is deceased.

	First Name	Last Name	Date of Birth (DD/MM/YYYY)	Percentage (Must total 100%)	Relationship
Contingent Beneficiary(ies)					
Contingent Beneficiary(ies)					

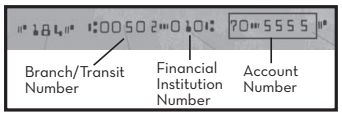
Trustee: A person given control or powers of administration of property held in trust with a legal obligation to administer it solely for the purposes specified. For designated beneficiaries considered a minor, a Trustee is to receive any amount due for any beneficiary considered a minor under the provincial jurisdiction of residence.

	First Name	Last Name	Date of Birth (DD/MM/YYYY)	Relationship
Trustee				

Note: Where Quebec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable unless you check the box marked "Revocable". I hereby make the above beneficiary designation: ☐ Revocable Beneficiary

5. DIRECT DEPOSIT

I may cancel this authorization at any time by giving 30 days written notice to Medavie Blue Cross.



Name(s) of Account Holder
(as it appears on the cheque): _____

Name of Financial Institution: _____

Address of Financial Institution: _____

Financial Institution Number (3 digits): _____ Branch/Transit Number (5 digits): _____

Account Number (7 - 14 digits): _____
(If your Account Number starts with a zero, be sure to include the zero. Do not Include dashes, hyphens or any other punctuation.)

6. PRIVACY CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-800-667-4511.

7. AUTHORIZATION

I certify that the information above is accurate and authorize payroll deductions, if required. I authorize Medavie Blue Cross to collect, use and disclose my personal information as described in the Privacy Consent section above.

Employee Name (please print): _____

Employee Signature: _____ Date (DD/MM/YYYY): _____

8. PRESCRIPTION DRUG INSURANCE (QUEBEC ACT)

All persons under 65 years of age who have access to a group insurance plan must enrol in the plan unless they already participate in another group plan or have insurance under a spouse's group plan. Proof of coverage must be kept on file with the employer.

By enrolling in your employer's group insurance plan, you are required to also arrange for coverage for all eligible dependents unless they are already covered under another group insurance plan.

Your dependents do not qualify for coverage under the RAMQ's basic prescription drug insurance plan if you already have coverage under an employer's group plan with the exception of a spouse aged 65 years or over.

When you complete your income tax return, you will be asked to confirm that you have complied with the provisions of the Act.

Enrolment Form

COMPLETE THIS FORM FOR THE ADDITION OF A NEW PLAN MEMBER

- Section ❶ to be fully completed by Plan Sponsor /Employer in ink.
- Sections ❷ to ❻ to be fully completed by Plan Member / Employee in ink
- Return the ORIGINAL to: (Mail) IATSE 514, 4530 Molson street, Montreal QC H1Y

1 Plan Sponsor / Employer Information

Client name

IATSE 514

Member #	Policy / group contract number
	164618

Insurance company name

CANADA LIFE

2 Plan Member / Employee Information

Last name		First name	
Middle initial	Gender ◉ M ○ F	Birth date _____ /_____ / _____	Marital status
Mailing address			
City	Province	Postal code	

3 Plan Member / Employee Coverage and Fmily Information

If you have a spouse and/or children, please complete the following section.

Spouse's last name	Spouse's first name	Spouse's birth date ___ /___ / ___	Province	Spouse's gender ○ M ○ F

Does your spouse have benefits through an employer plan? Myself: ○ Yes ○ No My spouse: ◉ Yes ○ No	If yes, please provide carrier/policy # :
If yes, please indicate spouse's coverage: Health ○ Single ◉ Family	Dental ○ Single ◉ Family

Child's full name (last, first)	DOB ___ /___ / ___	Province	Gender ○ M ○ F	Student ○ Oui ○ Non	Disabled ○ Oui ○ Non
Child's full name (last, first)	DOB ___ /___ / ___	Province	Gender ○ M ○ F	Student ○ Oui ○ Non	Disabled ○ Oui ◉ Non
Child's full name (last, first)	DOB ___ /___ / ___	Province	Gender ○ M ○ F	Student ○ Oui ○ Non	Disabled ○ Oui ○ Non

4 Waiver of Benefits

○ Individual coverage (if you haven't completed the previous section, than this option is selected as default).

○ Family coverage

If you or your dependents are presently covered for health and / or dental benefits under another benefits plan you may be able to waive coverage for such benefit(s) under this plan.

○ I waive coverage for myself and my dependents

○ I waive coverage for my dependents

If you waive health and / or dental coverage and later lose coverage through another plan, you may apply for benefits under this plan within 31 days. Otherwise you and/or your dependents may be required to provide proof of insurability, and your benefits may be limited or denied under this plan.

5 Plan Member / Employee Beneficiary Information

If you designate a beneficiary who is :

(a) Under 18 years of age, or
(b) Mentally incapacitated

you should also designate a Trustee for that beneficiary. If this situation applies to you or you have concerns about your named beneficiary's legal status, please consult a legal advisor for further details.

If you are a Quebec resident and you designate your spouse as a beneficiary, you are not permitted to change that beneficiary unless you :

(a) indicate that your designation of beneficiary is revocable, by checking the box on this form

(b) your spouse agrees, in writing, to be removed as your beneficiary

Original beneficiary information will be kept by your Plan Sponsor / Employer.

Name your beneficiary(ies)

Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated %
Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated %
Beneficiary's last name	Beneficiary's first name
Relationship to Plan Member	Percent allocated %

I appoint _____ as Trustee to receive any amount designated to a beneficiary who is under the age of 18 or mentally incapacitated.

For Quebec Residents Only
If you have designated your spouse as beneficiary, the designation will be irrevocable, unless you indicate that you wish it to be revocable below.

I wish to make my designation: ◉ Revocable ○ Irrevocable

6 Plan Member / Employee Declaration

In consent to the collection, use, and exchange of my personal information by my Plan Sponsor / Employer or the administrator, an insurance company, and / or others who require information to administer my group benefits.

I authorize these parties to obtain and exchange between them, any information about me, my spouse, and my dependent children to determine benefit entitlements, and for record keeping, file identification, reporting, underwriting, procurement of health information, claims adjudication and resolution, program management, and other services provided from time to time.

I confirm that I have obtained consent from my spouse and any dependent children over the age of majority, to share information as it relates to the plan.

I hereby apply for group benefits under m Plan Sponsor's / Employer's plan and authorize any required deductions.

I certify that the information given above is true and complete. A photocopy of this authorization is as valid as the original. The original enrolment form will be retained by my Plan Sponsor / Employer.

_____ _____

Plan Member / Employee signature Date signed

Application for membership in a group retirement savings plan

Return to Your plan administrator

In this application, "you" and "your" refer to the person who is applying to become an annuitant/member of the group retirement savings plan (the plan), and "we," "us," and "our" refer to the issuer, The Canada Life Assurance Company, 100 Osborne Street North, Winnipeg, MB R3C 3A5. We can be contacted at 1-800-724-3402 or by visiting grsaccess.com.

SECTION 1 – EMPLOYER/PLAN SPONSOR

Name of employer/plan sponsor	Policy/plan number
CANADIAN ENTERTAINMENT INDUSTRY RETIREMENT PLAN	**62724**

SECTION 2 – INFORMATION ABOUT YOU (please print)

Last name	Middle initial	First name	Division/subgroup	Identification/employee number
				N/A

Social insurance number (SIN)	Date of birth	Language	Email address
- - You authorize the use of your SIN for tax reporting, identification and record keeping	yyyy mm dd	☐ English ☐ French	Required for online access and to email information about the plan or services connected with it

Address (apt. no., street no., street)

City	Province	Postal code	Telephone no.	Alternate telephone no.
			- - Ext.	- -

If the above address is a PO box, general delivery or rural route, also include the civic or street address below

Address (apt. no., street no., street)	City	Province	Postal code

SECTION 3 – YOUR BENEFICIARY DESIGNATION

Where permitted by law, you can appoint one or more beneficiaries. Note: pension legislation may require payment of the death benefit to your qualifying spouse or common-law partner. All designations are revocable except in Quebec (see "Important: Quebec residents"). If you wish to designate an irrevocable beneficiary, complete the *Designation of irrevocable beneficiary* form.

Primary beneficiary(ies) on your death

Last name	First name	Date of birth yyyy mm dd	Relationship of beneficiary to you (Select box below **OR** Specify under Other)				% of benefit
			Married	Quebec civil union spouse	Common-law partner	Other (child, friend, etc.)	
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
							Total 100%

Important: Quebec residents

- If you appoint your married or civil union spouse as your beneficiary, they will be irrevocable (meaning you cannot change your beneficiary or perform certain transactions such as making withdrawals (where permitted) without their consent) unless you check the box below:
  I designate my married or civil union spouse revocably ☐
- The death benefit will be paid to the tutor(s) of a beneficiary who is a minor (generally the parents) or the tutor or curator of a beneficiary who otherwise lacks legal capacity unless a formal trust has been established by will or separate contract (in which case, designate the trust as beneficiary in this section)

Unless the law requires otherwise, if one of your primary beneficiaries predeceases you, their share will be paid to the surviving primary beneficiaries in equal shares, or if there is no surviving primary beneficiary(ies), to your contingent beneficiary(ies) named below. If there is no contingent beneficiary(ies), the benefit will be paid to your estate.

Contingent beneficiary(ies) on your death

Last name	First name	Date of birth yyyy mm dd	Relationship of beneficiary to you	% of benefit
				Total 100%

Application for membership in a group retirement savings plan (continued)

SECTION 3 – YOUR BENEFICIARY DESIGNATION (continued)

Trustee (to be completed if any of your beneficiaries are minors or otherwise lack legal capacity and do not reside in Quebec; do not complete if a formal trust exists)

Last name	First name	Trustee for (indicate beneficiary name)	Relationship of trustee to you

You authorize the trustee(s) named above 1) to receive benefits payable on behalf of any beneficiaries who are minors or otherwise lack legal capacity to give a valid discharge and 2) in their sole discretion, to use the benefits for the education or maintenance of the beneficiary and to exercise any right of the beneficiary under the plan. The trust will terminate once the beneficiary is both of age of majority and has capacity to give a valid discharge. Legal advice should be obtained prior to appointing a trustee. Payment to the trustee(s) discharges us to the extent of the payment.

SECTION 4 – YOUR INVESTMENT SELECTION (*Total allocation must equal 100%)*

Select investment(s) for your contributions, and if applicable, employer contributions. If a selection is not made, contributions will be invested in the default investment.

Target Risk Asset Allocation Funds

(Complete the Investment Personality Questionnaire to determine the fund most suited to you)

Conservative Portfolio (PSG)	LCOPO	_____ %
Moderate Portfolio (PSG)	LMOPO	_____ %
Balanced Portfolio (PSG)	LBAPO	_____ %
Advanced Portfolio (PSG)	LADPO	_____ %
Aggressive Portfolio (PSG)	LAGPO	_____ %

Target Date Asset Allocation Funds

(Select the Cadence Series below. Your contributions will be directed to the fund in the series that matures closest to the year in which you reach age 65)

Cadence Series (PSG) _____%

Cash and Cash Equivalents

Daily Interest Account	DIA	_____ %
5 Yr Compound Interest	CI5	_____ %

Balanced Fund

SRI Balanced (GWLIM)	SRBAL	_____ %

Default Fund – Cadence

The fund chosen will be the fund that matures to the year in which you turn 65 years of age)

Choose only if you would like to be invested in the Default Fund 100 % ☐

SECTION 5 – APPLICATION FOR REGISTRATION

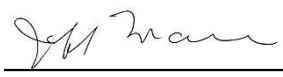
You apply for membership in the plan and authorize your plan sponsor to act as your agent for the purpose of the plan. You request that we apply to register the plan as a registered retirement savings plan under the *Income Tax Act* (Canada) and any similar provincial law.

SECTION 6 – SIGNATURE

You confirm the information on this form and will update it in the future as it changes. You have read the terms of the member's certificate and this application, including the attached Protecting your personal information, and agree to be bound by their terms. If locked-in pension funds are transferred to the plan, you agree and acknowledge that such funds will be governed by the locked-in retirement account addendum, locked-in retirement savings plan addendum, or restricted locked-in savings plan addendum, as applicable (the locked-in addendum), which will form part of the plan and will override the terms of the retirement savings plan certificate issued to you to the extent of any inconsistency between the certificate and the locked-in addendum. You are aware of the reasons the information covered by your authorizations and consents is needed, and the benefits of, and the risks of not, authorizing/consenting. You authorize and consent to us collecting, using, disclosing and retaining your personal information for the purposes outlined in Protecting your personal information. This authorization and consent is given in accordance with applicable law and without limiting the authorizations and consents given elsewhere in this application. If you cease to be eligible to participate in the plan and do not make an election in accordance with the terms of the plan, we are authorized to exercise transfer or withdrawal options provided in the plan, and you appoint us as your agent for this and any related purpose.

Signature of annuitant Date

President and Chief Executive Officer



President and Chief Operating Officer, Canada