24 Seeley Drive North York Ontario M3M2V6, Canada

DEPT OF BEREAVEMENT- AFRICAN CENTRE IN TORONTO

MEMBERSHIP COVERAGE APPLICATION FORM

MISSION STATEMENT

An organization dedicated to better the livelihood and quality of life of its members abroad and here in Canada. This can be achieved by providing them with an enabling environment to adjust while preserving their diverse background through fostering social and economic growth in the community by mentorship by promoting education, community involvement, and healthy living.

ACT SCOPE OF COVERAGE UNDER BEREAVEMENT DEPT

Fully paid members can cover their family members as indicted below and receive full benefits as stipulated in the constitution.

1. **Husband**
2. **Wife**
3. **Biological Child(ren)**
4. **Legally adopted child(ren)**
5. **Biological Parents (Father and Mother)**
6. **Biological Sibling(s)**

ACCEPTABLE METHODS OF PAYMENT

1. e-Transfer: e-mail treasury@africancentretoronto.org website: http://www.africancentretoronto.org
2. Bank Deposit: CIBC #

24 Seeley Drive North York Ontario M3M2V6, Canada

1: MAIN APPLICANT:

Name

Address

City

Province/Sta

Postal Code

Country

Phone NO

E-mail Address

2: Living Spouse (Husband or Wife):

The Spouse MUST be a **living** male or female in a documented and continuing relationship at the time of this application.

First Name

Middle Name

Last Name

Residence

3: Biological Parent(s)

The person(s) listed below must be **living** and one whose name is(are) documented in your birth certificate as the father or mother. The name(s) must appear as listed in the birth certificate.

Father's Full Name

Residence

Mother's Full Name

Residence

4: Biological child(ren)

The "Biological child(ren)" must be a **living** son or daughter whose birth certificate references the present parent(s).

1: Full Name

Residence

2: Full Name

Residence

3: Full Name

Residence

4: Full Name		Residence	
5: Full Name		Residence	
6: Full Name		Residence	

5: Legally adopted child(ren)

The child(ren) must be **living** and the applicant must show original legal documentation(s) that show the transfer of rights and responsibilities from the biological parent(s) to you.

Full Name		Residence	
Full Name		Residence	

5: Biological Sibling(s)

Biological Sibling(s) must be a **living** brother or sister born from the same mother as the applicant.

1: Full Name		Residence	
2: Full Name		Residence	
3: Full Name		Residence	
4: Full Name		Residence	
5: Full Name		Residence	
6: Full Name		Residence	
7: Full Name		Residence	
8: Full Name		Residence	
9: Full Name		Residence	
10: Full Name		Residence	

7: Other Family Members (brother(s)/Sister(s) enrolled in African Center in Toronto department of Bereavement.

1: Full Name		2: Full Name	

8: Nomination of Next of kin/Beneficiary

Nominate a person that can receive your benefits in case of your absence or become incapacitated medically or otherwise. This name can be updated anytime conditions change by filling and signing a new membership form.

Name

E-Mail address

Address

Cell Phone

City

Province

Zip Code

Relationship

Country

Current Residence

9: Declaration

By printing, signing, and dating, or typing, dating, and submitting this form by e-mail, fax, or otherwise,

I applicant, agree to ALL the following conditions including:

a). That the information provided in this application is correct and can provide a proof if required to.

b). I will adhere to clause 10.0 Code of conduct " ...shall maintain membership in good standing for a period of three. years from the date of the last benefits and shall not resign or leave the bereavement .... "

c). That I may be required to provide additional documentation in case of suspected fraud or for clarification purposes.

d). That I will be legally required to refund ACT all money received and be banned for life in case of proven fraud.

e). That in case I am sued for fraud, I will refund ACT all the costs incurred in addition to the money received.

f). That the document I am signing today is legally binding.

Full Name

Today's Date