CINUP

CONFIRMATION OF SCHOOL ATTENDANCE

JG11-CU

Use this form to apply for group benefit coverage for over age dependent children who are full-time students. Send the completed form to CINUP at the address below.

1

Employer Name _____

Employee Name _____ Certificate # _____

2

Dependent's Name	Name and location of educational institution attended on a full-time basis	School Year Start (YYYY/MM/DD)	End
		/ /	/ /
		/ /	/ /
		/ /	/ /

Children may be covered up to their 26th birthday if they are unmarried full-time students and dependent on the Employee for support. Confirmation must be forwarded to JG Benefits Inc. each year for dependents over the age of 21 and under the age of 26 in order to be eligible for coverage.

3

Please note full-time students attending school outside of Canada are not eligible for the Travel Health Benefits and the International Travel Assistance coverage.

1) Is the over age dependent(s) wholly dependent upon you? ☐ Yes ☐ No

2) Is the dependent in full-time attendance at an accredited school? ☐ Yes ☐ No

If 'Yes', expected date of graduation _____

If the student plans to pursue post-graduate studies after this date, please indicate:

Date _____ Name & location of school _____

4

Authorization and Consent

I understand the personal information provided herein as well as any other personal information currently held or collected in the future by JG Benefits Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and service to me and my employer, and to manage the organization'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 include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand the personal information will be kept confidential and secure. I understand I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I acknowledge more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.cinup.ca or from the administrator of my benefit program.

I certify all information contained herein is correct. If applying for coverage for my dependents, I confirm I am authorized to act on their behalf.

Employee Signature _____ **Date** _____

CINUP | 1051 King Edward Street | Winnipeg, MB | R3H 0R4 | TF 1 800.665.1234 | TF Fax 1 833.702.4687 | eebenefits@cinup.ca