CINUP

ENROLMENT APPLICATION

JG10-CU

Please complete in ink. Mail, email or fax the completed form to CINUP and keep a photocopy for your records.

For CINUP use only: Certificate #_____

TO BE COMPLETED BY EMPLOYER (Please print clearly in INK)

Employer Name _____

Firm Number _____ Date of Employment (YYYY/MM/DD) _____

Employee Occupation _____ Waive waiting period? ☐ Yes ☐ No

Regular Earnings _____ Frequency ☐ Annually ☐ Bi-Weekly ☐ Weekly ☐ Semi-Monthly ☐ Monthly ☐ Hourly

hours/week _____

Is Status employee tax exempt (for RST purposes)? ☐ Yes ☐ No Status Registry Number (10 digits) _____

I certify this employee has been employed full time continuously since the date shown and is working at least the minimum hours as outlined in the General Provisions section of our Master Application or Contract. If the hourly wage is provided but the number of hours per week is not, it will be assumed 40 hours.

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

EMPLOYEE INFORMATION (To be completed by the employee — Please print clearly in INK)

Employee's Name _____
LAST FIRST INITIAL

Gender ☐ Male ☐ Female Date of Birth (YYYY/MM/DD) _____

☐ Non-Status Participant ☐ Status Participant

Marital Status ☐ Single ☐ Common Law — Date Started Living Together (YYYY/MM/DD) _____
☐ Married ☐ Divorced ☐ Separated

Home Mailing Address (Number, Street, Apt. Number, PO Box Number) _____

City/Town _____ Province _____ Postal Code _____

Phone (_____) _____ Email Address _____

DIRECT DEPOSIT

By completing the banking information below, I authorize CINUP to deposit my Health and/or Dental benefit payments into this account.

Branch/Transit Number _____ Bank Number _____ Account Number _____

COVERAGE REQUESTED

You may waive Extended Health Care and Dental Care Benefits for yourself and your dependent(s) ONLY if you are covered for similar benefits under your spouse's plan. You may apply at a later date for benefits you have waived but certain restrictions may apply. Please see your Plan Administrator for details.

Do you or your dependents have other coverage ☐ No ☐ Yes

Name of Insuring Company _____ Policy Number _____

Other plan includes coverage for Extended Health ☐ Family ☐ Single ☐ None
Dental ☐ Family ☐ Single ☐ None

Are you waiving coverage for Extended Health ☐ No ☐ Yes, for myself and my dependents ☐ Yes, for my dependents only
Dental ☐ No ☐ Yes, for myself and my dependents ☐ Yes, for my dependents only

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DEPENDENT INFORMATION — List your spouse and children below (Required for coverage such as Dependent Life, Extended Heath Care and Dental) Dependents age 21 and over must be full-time students. If applicable, please complete the Confirmation of School Attendence form.

First Name	Last Name	Status	Date of Birth (YYYY/MM/DD)	Gender	Relationship
		☐ Status ☐ Non-Status		☐ M ☐ F	
		☐ Status ☐ Non-Status		☐ M ☐ F	
		☐ Status ☐ Non-Status		☐ M ☐ F	
		☐ Status ☐ Non-Status		☐ M ☐ F	
		☐ Status ☐ Non-Status		☐ M ☐ F	

BENEFICIARY DESIGNATION — Please print clearly in INK (If information is revised, have employee initial)

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.
(If you designate more than one beneficiary, please indicate what portion of the benefit each individual is to receive and ensure the total adds up to 100%.)
Or, check here if you wish the benefit **equally split** among the listed beneficiaries. ☐

First Name	Last Name	Initial	Relationship	Date of Birth (YYYY/MM/DD)	% of Benefit (must equal 100%)

If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support of education of the minor.

Trustee Name _____ **Relationship** _____

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 services 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 and hereby confirm the beneficiary designation and authorize payroll deductions, if required.

I understand the coverage will only be effective if this application is accepted by the insurance carrier and such coverage shall not be effective prior to the effective date as outlined in the agreement between the insurance carrier and my employer.

If applying for coverage for my spouse and/or dependents, I confirm I am authorized to act on their behalf.

Signature of Applicant _____ **Date** _____