CINUP

ENROLMENT APPLICATION CHIEF & COUNCIL AND/OR APPOINTED OFFICIAL

JG10-CU

Please mail the original completed in ink to CINUP and keep a photocopy for your records.

For CINUP use only: Company #_____
Firm #_____
Certificate #_____

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

Employer Name _____

Employer Code _____ Date of Elected (YYYY/MM/DD) _____

Job Title _____

Is Status employee tax exempt (for RST purposes)? ☐ Yes ☐ No

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

APPLICANT INFORMATION (To be completed by the applicant — Please print clearly in INK)

Applicant's Name _____
LAST FIRST INITIAL

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

☐ Non-Status Participant ☐ Status Participant Status Registry Number (10 digits) _____

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

Address (Number, Street, Apt. Number) _____ City/Town _____

Province _____ Postal Code _____ Phone (_____) _____

Email Address _____

DEPENDENT INFORMATION — List your spouse and children below (Please print clearly in INK)

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
Spouse or Common Law			☐ Status ☐ Non-Status		☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	
Dependent Children			☐ Status ☐ Non-Status		☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	
			☐ Status ☐ Non-Status		☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	
			☐ Status ☐ Non-Status		☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	
			☐ Status ☐ Non-Status		☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	

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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.

Extended Health Care (check one ONLY)

☐ Single
☐ Family
☐ Waive: Name of Other Insurer

_____

Dental Care (check one ONLY)

☐ Single
☐ Family
☐ Waive: Name of Other Insurer

_____

BENEFICIARY DESIGNATION — Please print clearly in INK (If information is revised, applicant must 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%.)*

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.

I accept the terms of the Privacy Policy, and I understand that I can refer to www.cinup.ca or contact the CINUP Privacy Compliance Officer for more specific information about collection and use of my personal information and my questions about privacy. I acknowledge that I have reviewed the Privacy Policy. The non-exhaustive list of sources that personal information can be collected from and disclosed to includes myself, medical and health professionals, facilities or providers, insurance companies, or other organizations/persons.

I understand the personal information will be kept confidential and secure. I understand I may revoke my consent at any time.

I understand that I have the right to request access to the relevant personal information that CINUP holds in my file, and to have this information corrected or deleted as necessary.

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.

Any copy of this authorization shall be as valid as the original.

Signature of Applicant _____ **Date** _____