CINUP

ENROLMENT APPLICATION

JG10-CU

TO BE COMPLETED BY EMPLOYER

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.

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

EMPLOYEE INFORMATION (To be completed by the employee)

Employee's Name _____
LAST FIRST INITIAL

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

☐ Non-Status Participant ☐ Status Participant

Marital Status ☐ Single ☐ Common Law — Date of Cohabitation (YYYY/MM/DD) _____
☐ Married ☐ Separated
☐ Widowed ☐ Divorced

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.

First Name	Last Name	Status	Date of Birth (YYYY/MM/DD)	Gender	Relationship	Full-Time Student (age 21 - 25)	Disabled Dependent (age 21 or over)
		☐ 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		☐	☐

BENEFICIARY DESIGNATION (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%)

To add additional or contingent beneficiaries, please complete a separate Appointment of Beneficiary form.

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** _____