CINUP

ENROLMENT APPLICATION

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)

☑ New Employee ☐ Reinstatement

Employer Name Nishnawbe-Aski Legal Services - Contract Employees

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

Employee Occupation _____

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

hours/week _____

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

Waive waiting period? ☐ Yes ☐ No

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

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

Employee's Name Honan-Bouchard, Roderick A
LAST FIRST INITIAL

Gender ☑ Male ☐ Female Date of Birth (YYYY/MM/DD) 1989/01/25

Aboriginal Status ☐ Non-Status ☑ Status Status Registry Number (10 digits) 1880049902

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

Address (Number, Street, Apt. Number) 367 Valley Street City/Town Thunder Bay

Province Ontario Postal Code P7B 6L3 Phone (807) 628-4350

Email Address rodbouchard224@hotmail.com

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	Aboriginal Status	Date of Birth (YYYY/MM/DD)	Gender	Relationship
Spouse or Common Law			☐ Status ☐ Non-Status		☐ M ☐ F	
Dependent Children			☐ Status ☐ Non-Status		☐ M ☐ F	
			☐ Status ☐ Non-Status		☐ M ☐ F	
			☐ Status ☐ Non-Status		☐ M ☐ F	
			☐ Status ☐ Non-Status		☐ M ☐ F	

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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)

- [x] Single
- [ ] Family
- [ ] Waive: Name of Other Insurer

_____

Dental Care (check one ONLY)

- [x] Single
- [ ] Family
- [ ] Waive: Name of Other Insurer

_____

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%.)*

First Name	Last Name	Initial	Relationship	Date of Birth (YYYY/MM/DD)	% of Benefit (must equal 100%)
Karen	Honan	E	Mother	1961/03/03	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** Apr. 1/22