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

Employer Code _____ Date of Employment (YYYY/MM/DD) 2023/11/13

Employee Occupation Youth Intervention Worker.

Regular Earnings $47,286 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 [signature] Date (YYYY/MM/DD) 2024/03/13

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

Employee's Name Meekis (LAST) Lakeishia (FIRST) B (INITIAL)

Gender ☐ Male ☑ Female Date of Birth (YYYY/MM/DD) 2001/19/12

Aboriginal Status ☐ Non-Status ☑ Status Status Registry Number (10 digits) 2110403701

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

Address (Number, Street, Apt. Number) PO Box 124 City/Town Sandy Lake

Province Ontario Postal Code P0V 1V0 Phone (807) 633-5550

Email Address lakeishiameekis@gmail.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%) |
|---|---|---|---|---|---|
| Geron | McKay | G.M | Brother | 2012 06/24 | 25% |
| Taria | McKay | T.M | Brother | 2011 11/24 | 25% |
| AJ | McKay | A.M | Brother | 2006 12/13 | 25% |
| Kaydence | Meekis | K.M | sister | 2005 03/27 | 25% |

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** Kaydence Meekis **Relationship** Sister

## 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** Jakeriahna Meekis **Date** 12/03/2024