CINUP

EMPLOYEE CHANGE REQUEST

JG11-CU

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

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

Employer Name			Employer Code
Employee Name			Certificate #
☐ Occupation Change	New Occupation		Effective Date (YYYY/MM/DD)
☐ Salary Change	Earnings	☐ Annually ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Hourly	# Hours/Week
Effective Date of Salary Change (YYYY/MM/DD)			
Authorized Employer Signature			Date (YYYY/MM/DD)

2 TO BE COMPLETED BY EMPLOYEE (Please print clearly in INK)

☐ Address Change	New Address	
☐ Name Change	From	Phone ( )
	To	
	Reason for Change	
☐ Email Address Change		
☐ New Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	Date of Change (YYYY/MM/DD)
	☐ Common Law – Date of Cohabitation (YYYY/MM/DD)	
☐ Add Benefits	☐ Health ☐ Dental	
☐ Remove Coordination of Benefits	☐ Yes ☐ No If Yes, date spouse's coverage terminated (YYYY/MM/DD)	
☐ Add Dependent(s)	Please complete section 3	
☐ Waive Health and/or Dental	☐ Health ☐ Dental Effective Date of Change (YYYY/MM/DD)	
☐ Change Level of Coverage	☐ Change from family to single coverage (YYYY/MM/DD) ☐ Change from single to family coverage (YYYY/MM/DD)	

3 LIST ALL YOUR DEPENDENTS AFFECTED BY THE CHANGE, INCLUDING YOUR SPOUSE

(Please print clearly in INK)

	Date of Change (YYYY/MM/DD)	First Name & Initial (last name if different)	Relationship	Birthdate (YYYY/MM/DD)	Aboriginal Status	Gender
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F
☐ Add ☐ Delete					☐ Status ☐ Non-Status	☐ M ☐ F

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CINUP

EMPLOYEE CHANGE REQUEST

JG10-CU

BENEFICIARY DESIGNATION – Please print clearly in INK (crossed out or revised info must be initialled by employee)

First & Last Name	Middle Initial	Date of Birth (YYYY/MM/DD)	% of benefit	Relationship

☐ **Additional Beneficiaries** ☐ **Contingent Beneficiaries** (Secondary beneficiary if the above beneficiary is deceased)

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First & Last Name	Middle Initial	Date of Birth (YYYY/MM/DD)	% of benefit	Relationship

Trustee/Administrator Designation

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

Full Name _____ Relationship _____

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

EMPLOYEE SIGNATURE (Please sign and date below)

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 may 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 service 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.

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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.

Employee Signature _____ **Date** _____