Manulife

Group Benefits Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Statement Plan sponsor name NiShnaube-Aski Legal Services Corp. Plan contract number	
Plan member's certificate number	
621	
Do you want the waiting period added to the hire date? Yes No Permanent hire date (dd/mmm/yyyy)	sne,
Re-hire date (dd/mmm/yyyy) If a re-hire, date previous employment ended (dd/mmm/yyyy)	
Occupation Class Hours worked/week 35 Salary \$ 45,000 Frequency	A
certify that the plan member listed below is actively at work at their usual place of employment in Canada. Actively at work means the plan member normal work schedule of at least the set minimum hours per week as stated in the plan contract over a 52 week period including paid vacation.	er work
Plan administrator signature Date (dd/mmm/yyyy)	CIJI
Is evidence of insurability required? Yes No (in order to determine if evidence of insurability is required, please	e refer to
your contract.) If yes, please complete form GL0004E and send to Manufife for processing.	
Plan member information Plan member's last name Napash First name Heather	
To be completed by Date of birth (dd/mmm/yyyy) 31/10/1985 Gender OMale Female Province of residence ON	
employee Language & English French Do you have a spouse? (married, common law or civil union?) Yes No	
Plan member address (number, street, apt.) 109 Kensington Drive	
city Thurder Boy Province ON Postal code P7C 2A	4
For Quebec residents (age 65 or over) Are you participating in the RAMQ drug plan? Yes No	
Application for Some plans allow refusal of certain benefits if the plan member has coverage under their spouse's plan. If you wish to add coverage a later date, you may reapply for these benefits at which time satisfactory medical evidence may be required.	erage at
I am applying for Extended Health Care for I am applying for Extended Dental Care for	
○ Myself only	
 Myself and 1 dependant (child or spouse) Myself and 1 dependant (child or spouse) 	
Myself and 2 or more dependants (spouse and children) Myself and 2 or more dependants (spouse and children)	hildren)
○ None, because my spouse has coverage	
Are you applying for Dependant Life? Yes ONo Dependant Life may be mandatory. Refer to the policy details.	
Coordination This section is required if you are applying for coverage on your dependants.	
of benefits Do you or your dependants (spouse and/or children) have benefit coverage under another benefits plan? Yes No	
If yes, please provide the following details: Name of other insurer	
sured's last name Date of birth (dd/mmm/yyyy)	
fective date of coverage (dd/mmm/yyyy) Delicy number Policy number Pol	
HN	
ease Indicate type of coverage under other plan: Extended Health Benefits Dental Care Single Single	
cases where the information is not complete a Couple Couple	
Family Family	
O None O None	

	In Section 5 Appli	wing section if the placetion for coverage.		and/or denial coverage ar				
Spouse if there is not enough	Last name							
room to list your	Gender OMak	e OFemale If	common law, pleas	se provide the effective da	te of cohabitation	(dd/mmm/	'	
dependants, attach details on a separate sheet.	**To apply for ove	r-ago disabled depen	dant coverage, ple	ase complete form GL051				•
Last name		First name		Date of birth (dd/mmm/yy	yy) Male	ender Female	Over-age student	Over-age disabled dependant*
Thompson		Ryder		18/06/200	4 0	0	0	0
Thompson		Karma		19/09/3001	<u> </u>	Q	0	0
Thompson		Rowlin		14/11/2008	<u></u>	0	0	0
						0	0	0
8 Direct deposit	Transit number	70927						
Complete the following section if you would	institution number	003		**************************************	Low population			
like to sign up for direct deposit of your claim payments.		nber <u>038393</u>	<u> </u>		stitution number		number	
Electronic claim	By providing your	email address, you w	ili recelve an Invita	tion to register for an onli				
statement	Work email address	# <u>hnapash@</u>	contegation	<u>},CC</u> Personal email add	iress <u>heathe</u>	coope	sh@gn	<u>iail-c</u> or
9 Authorization								
true and complete to the provided by me, and/or portion of this Coverage i authorize Manulife to plan administration, and or organization with Inforplan administrator, insureach other and with Ma on their behalf as if they deductions from my pay	e best of my knowle my Dependants, in a, and future claims collect, use, mainta dit, assessment, invo primation, including a rer, investigative ag mulife, its reinsurers y were signing it the y for my Group Bene	dge. Lunderstand the future is true and thereunder may be d in and disclose perso estigation, claim maniny medical and healt ency, and any adminiandor its service promselves, and to discletills plan, if applicable	at as the applicant complete to the be ented or terminate and information reliagement, underwrith professionals, fastrators of other be oviders, for the Purose and receive the Lauthorize the use. Lauthorize the use.	ts (collectively, "Depender, it is my responsibility to east of our knowledge. Lag do as a result of the provision of the providers, professionally propers. Lam authorized beir Information, for the Public I is my response to collect poses. Lam authorized beir Information, for the Public I is my response to the provision of the	ensure that any fi knowledge and on of false, incon information") for lan eligibility ("Pu ssignal regulatory use, maintain ar y my Dependent	urther verba agree that I aplete, or m he purpose rposes"). L bodies, an d exchang s to consen se my plan	al or written in a Coverage is leading in a sof Group authorize a sy employer, e this Information to this Authorian authorian a this Information authorian a	statement ge or any formation. Benefits my person , group
If applicable I suth sele	a Manulifa to denne		ate number. <u>Lagre</u>	se of my Social Insurance a a pholocopy or electron			ooses of ide	horization, make
account ("Account") tha me and any other finand lunderstand and egre Payment(s). I also und herein, and require my Manulife into the Accou Manulife, either by me o	it I have identified or cial institution I choo te that upon the dep erstand and agree personal written end nt, to which I am no or by representative	n this form. I confirm use to name in the full osit of any Payment(s that Manulife may, at lorsement relating to t entitled, either by co s of my estate.	ments") due to me that this direct bar ure; and shall rema s) into the Account i any time and with future Payment(s), untract or by law, sl	ise of my Social Insurance a a pholocopy or electron from the above reference ak deposit authorization ap ain valid until revoked in w Manulife is fully discharg out prior notice, discontine Laiso hereby acknowle all not form part of my pre-	ic version of this if Group Benefits plies to the finanting by me, or ned from any furthe the direct dependent agree the perty, and shall in the control of the shall in the s	authorization policy ("Policy ("Policy ("Policy of pauthors of payment any Pay	ooses of Ide in is valid. icy"), into the on herein na iorized repro elth respect nent(s), as na ment(s) ma tely refunde	horization, make intification as bank arned by esentative. to such equested ide by ed to
account ("Account") that me and any other finance Understand and egge Payment(s). I also understand require my Manulife into the Account Manulife, either by me of If applicable, Lauthoriz understand such correction. Lagree Manulife or by me purst	It I have identified or cial institution I choose that upon the depersion and sqree personal written enout, to which I am no or by representative a Manulife to correspondence may corpute that Manulife is not until to this authoriza Manulife. I understa	this form. I confirm the fut cost of any Payment(s) that Manulife may, at lorsement relating to the entitled, either by cost of my estate, pond with me through that in Information; and the liable for damages watton. I agree should	ments") due to me that this direct ben ure; and shall rem s) into the Account i any time and with future Payment(s), untract or by law, si in the email address that the Informatic which I may incur a the email address the email address	ise of my Social Insurance a a pholocopy or electron from the above reference ak deposit authorization ap ain valid until revoked in w Manulife is fully discharin out prior notice, discontin Laiso hereby acknowle	ic version of this if Group Benefits plies to the finantiting by me, or ned from any furthe the direct depote and agree the perty, and shall garding my Cover that is not guay a third party of non that I am res	authorization policy ("Policial institution duly authorization policial pol	noses of ide on is valid. licy"), into the on herein na orized repro- vith respect tent(s), as re- ment(s) ma tely refunde e Purposes, a secured na ansmission s r undating ti	horization, make milification make milification make milification make milification make milification make a milification make milification mi
account ("Account") that me and any other finant understand and agre Payment(s). I also understand, and require my Manulife into the Accound Manulife, either by me of the applicable, authoriz understand such correct communication. lagree Manulife or by me pursuaddress maintained by Customer Service Centerstand that any disability file. Access to Manulife empkores persons to who persons to who persons author	it I have identified or cial institution I choose that upon the deperstand and agree personal written end int, to which I am no or by representatives a Manulife to corresspondence may core that Manulife is not uant to this authorized. I understier. I understier. Information provided my information will oppes, representative or I have granted a rized by law.	a this form. I confirm see to name in the full osit of any Payment(s that Manulife may, at lorsement relating to a entitled, either by costs of my estate. pond with me through stain Information; and aliable for damages watton. I agree should and that if I do not wis to or collected by Mabe limited to: ses, reinsurers, and seccess; and	ments") due to me that this direct ber ure; and shall rems) into the Account any time and with future Payment(s), ontract or by law, si the email address the email address sh to receive email anulife in accordant ervice providers in	use of my Social insurance a pholocopy or electron from the above reference as deposit authorization apain valid until revoked in w. Manulife is fully dischargout prior notice, discontinuals of the part of my properties and the period of the form remains being sent in a manular action of interception bedentified on this form chas from Manulife, I can remove with this authorization, the performance of their justice.	ic version of this if Group Benefits plies to the finanting by me, or ned from any furthe the direct deprize and agree the perty, and shall garding my Coveer that is not guay a third party of nge that I am resove my email adwill be kept in a sobs;	authorization policy ("Policial institution of usual parties of Paymat any Paymat any Paymoe immedia rage, for the ranteed as an email traponsible for dress online Group Bene	osses of ide in is valid. licy"), into the on herein na orized repro- vilth respect tent(s), as nament(s) ma tely refunde e Purposes, a secured na namission : r updating the e or by cont	horization, make antification when the care of the care of sent by the care of sent by the care of sent by the email the care of the care
account ("Account") that me and any other finant understand and egre Payment(s). I also und herein, and require my Manuilfe into the Accound Manuilfe, either by me of the first of the	it I have identified or cial institution I choose that upon the deperstand and agree personal written enough to which I am not by representative a Manulife to corresspondence may core that Manulife is not uant to this authorizadanulife. I understier. Information provided my information will born I have granted a rized by law, ast access to the personal institution of the personality are specific details respectific details respectific details respectific details respective institution of the personality of the personality are specific details respective institution of the personality are specific details respective institution of the personality and the personality are specific details respective institution of the personality and the personality are specific details respectively.	a this form. I confirm see to name in the full osit of any Payment(s that Manulife may, at lorsement relating to a entitled, either by cos of my estate. pond with me through the information; and liable for damages watton. I agree should and that if I do not wis be limited to: es, reinsurers, and secess; and sonal information in regarding how and why	ments") due to me that this direct ber ure; and shall rems) into the Account; any time and with future Payment(s), ontract or by law, si the email address in the email address sh to receive email anulife in accordant ervice providers in my file, and, where y Manulife collects.	ise of my Social Insurance a pholocopy or electron from the above reference ask deposit authorization apain valid until revoked in w. Manulife is fully dischargout prior notice, discontint I also hereby acknowletall not form part of my properties is being sent in a manner a result of interception be dentified on this form chas from Manulife, I can remove with this authorization,	ic version of this id Group Benefits plies to the finanting by me, or ned from any furthe the direct depart and agree the garding my Cover that is not guay a third party of nga that I am resove my email adwill be kept in a will be kept in a cobs;	authorization policy ("Policial institution y duly authorization policial institution y duly authorization policial information policial information correctation ("Policial information policial information correctation correct	poses of ide on is valid. licy"), into the on herein na lorized report whent(s), as me ment(s), as me ment(s) ma dely refunde e Purposes, a secured na ansmission a r updating the e or by cont	horization, make intification when the marke intification when the market into such equested do by and to to the means of sent by the email acting the mail acting the mail intification.

10 Mailing instructions

Plan Member Administration Manulife Financial PO BOX 11006, STN CENTRE-VILLE MONTREAL QC H3C 4T8



Group Benefits Beneficiary Designation

Please see reverse for assistance in completing this form.

Send the completed form to: Plan Member Administration

Manulife Financial

PO BOX 11006, STN CENTRE-VILLE MONTREAL QC H3C 4T8 Fax: 1-877-733-4233

All sections of this page should be completed as it will replace any prior designations.

1	Plan member information	Plan sponsor name	^	Plan contract number		Plan member certificate n	umber
	1	Nishnowbe-Acki Legal Services O	OVP	Province of residence	-	Date of birth (dd/mmm/yy)	- p./
		#Naposh, Heather J		6N		31/10/1985	
2	Primary beneficiary	Name of beneficiary (last, first and middle initial)		of birth (dd/mmm/yyyy) 06 2004	1	ationship to plan member	~~~
	List all primary beneficiaries for Basic Life and/or Basic Accidental	Thompson Ruder Q Name of behoticiary (last, first and middle initial)		of birth (dd/mmm/yyyy)		• •	
	Death.	Thompson, Karma B	12	109/2006		aughter	34 %
	Percentages must total 100% to be valid.	Name of beneficiary (last, first and middle initial) Thompson, Rowlin R		of pirth (ad/mmm/yyyy)	1	ationship to plan member	Percentage %
	Irrevocability	Brains 1) Lincolais		For Qu	nepec	c residents only	
			In Q	uniess	s other	ur spouse as beneficiary is erwise specified.	inevocable
			_	If spouse is be		ciery, the designation is: irrevocable	
3	Optional coverage (if applicable)	Name of beneficiary (last, first and middle initial)	Date	of birth (dd/mmm/yyyy)	Rela	ationship to plan member	Percentage %
	Plan contract number	Name of beneficiary (last, first and middle initial)	Date			ationship to plan member	%
	List all beneficiaries for Optional Life and/or Optional Accidental Death.	Name of beneficiary (tast, first and middle initial)	Date o	of birth (dd/mmm/yyyy)	Rela	ationship to plan member	Percentage %
	Irrevocability		in C	Quebec, the designation o	of you	o realdenta only ur spouse as beneficiary is	s irrevocable
				If spouse is be	enefici	erwise specified. ciary, the designation is:	
_				○ Revoca	ble	O Irrevocable	
4	Contingent beneficiary						
		Name of contingent beneficiary (last, first and middle initial	n I	Date of birth (dd/mmm/y)	~VV)	Relationship to plan me	ember
						1 Marian	lime.
		Name of contingent beneficiary (tast, first and middle initial		Date of birth (dd/mmm/y)	YYY)	Relationship to plan me	mber
5	Trustee appointment	i i m dii					
	Complete if any beneficiary named is under the age of majority.	I appoint <u>Jessie Mo-Hinas</u> any beneficiary under the age of majority (not applicable in	n Quet		as Tr	rustee to receive any amor	unt due to
6	Declaration and	I hereby revoke any previous beneficiary designation			ning (∽verace(s) and design	nate the
	authorization	person(s) named above.					
	Due to the legal significance of a beneficiary appointment this	At Manulife Financial, we know that confidentiality of to us will be kept in a Group Life and Health Benefit to us will be representatives in the confidence of the confidence	its file.	. Access to your inform	matio	ant. Any information you will be limited to:	in blovide
	designation must be signed and dated to be valid.	 our employees and service representatives in the persons to whom you have granted access; and persons authorized by law. 		normance or men job.	s;		
	A copy, fax, scan or image of the beneficiary designation in this form	You have the right to request access to the personal information.	al infor	mation in your file an	d, if i	necessary, correct any	inaccurate
	is as valid as the original.	<u>Facknowledge</u> that more detailed information conc discloses my personal information is available at we plan sponsor.	emin; ww.m:	g how and why Manul anutife.ca/planmembe	life F er, or	Inancial collects, uses by requesting a copy (and from my
		Plan member signatura				Date signed (dd/mmm/y	(אנאי
	7	Hinapost .				Declo	

Manulife

Group Benefits Enrolment or Re-enrolment Application

Please print clearly in dark ink using CAPITAL LETTERS.

Section 1 is to be completed by the plan administrator. The remaining sections and Beneficiary Designation form are to be completed by the plan member.

1	Plan sponsor statement	Plan sponsor name Nishnaube-	Aski Legal Services Con	Plan contract number		
		Billing division Acc	ount/Division number	Plan member's certificate number		
		Do you want the waiting period added	to the hire date? OYes ONo	Permanent hire date (dd/mmm/yyyy) 22/UNE /		
		Re-hire date (dd/mmm/yyyy) Occupation		evious employment ended (dd/mmm/yyyy)		
l c	certify that the plan n normal work schedule	nember listed below is actively at wor e of at least the set minimum hours per	k at their usual place of employment week as stated in the plan contract of	in Canada. Actively at work means the plan member works over a 52 week period including paid vacation.		
		Plan administrator signature	8	Date (dd/mmm/yyyy) UTIDEC(30)		
		Is evidence of insurability required?	your contract			
	-	If yes, please complete form GL00046	and send to Manulife for processing).		
2	Plan member information	,	1 00 00	First name Heather		
	To be completed by	Date of birth (dd/mmm/yyyy) 31/1	0/1985 Gender OMale			
	employee	Language Ø English O French	Do you have a spouse? (man	ried, common law or civil union?) O Yes Vo		
3	Plan member address	Address (number, street, apt.) 100	Rensington Dr	ive		
		city Thursder Boy	Pro	ovince ON Postal code P7C QA4		
4	4 For Quebec residents (age 65 or over) Are you participating in the RAMQ drug plan? Yes No					
5	Application for coverage	Some plans allow refusal of certain be a later date, you may reapply for thes		age under their spouse's plan. If you wish to add coverage at		
		I am applying for Extended Health Ca	2	am applying for Extended Dental Care for		
		Myself only		Myself only		
		Myself and 1 dependant (child or	spouse)	Myself and 1 dependant (child or spouse)		
		Myself and 2 or more dependant	s (spouse and children)	Myself and 2 or more dependants (spouse and children)		
		O None, because my spouse has o	overage	None, because my spouse has coverage		
		Are you applying for Dependant Life?	√Yes No Dependent Life No Dependent Life	e may be mandatory. Refer to the policy details.		
6	Coordination of benefits	This section is required if you are app Do you or your dependants (spouse a		rts. e under another benefits plan? ○Yes ਓNo		
		If yes, please provide the following de	tails: Name of other insurer_	· · · · · · · · · · · · · · · · · · ·		
In	sured's last name	F	rst name	Date of birth (dd/mmm/yyyy)		
Ef	fective date of covera		dentification/certificate number	Policy number		
PI	ease indicate type of	HN coverage under other plan:	Extended Health Benefits	Dental Care		
	- MODEL AND LOCATE CONTRACT CONTRACT AND THE CONTRACT CON		○ Single	○ Single		
In cases where the information is not complete a default value will be applied.			O Couple	Couple		
			Family None	○ Family ○ None		
			1755 - 0000001/TS	- acceptation		
_		The second secon				

7 Dependant information	Complete the following section if the plan including Section 5 Application for coverage,	les health and/or dental coverage and you	have not r	efused ben	elils for you	r dependants				
Spouse If there is not enough	Last name Date of birth (dd/mmm/yyyy)									
room to list your	Gender OMale OFemale If common	law, please provide the effective date of co	ohabitation	(dd/mmm/	уууу)					
dependants, attach details on a separate	**To apply for over-age disabled dependant cov	verage, please complete form GL0514E.								
sheet. Last name	First name	Date of birth (dd/mmm/yyyy)	G Male	ender Femal a	Over-age student	Over-age disabled				
Thompson	Ryder	18/06/2004	_ &	О	0	dependant**				
Thompson	_	13/09/2006	_ 0	Ø	0	0				
Thompson	Rowlin	14/11/9008	_ 🖋	0	0	0				
			_	0	0	0				
8 Direct deposit	Transit number 7022									
Complete the following section if you would	Institution number 00 2	" MEND	<u> </u>			7				
like to sign up for direct deposit of your claim		- injude tiuty ssideroit	000 F F=10	<u> Billin</u>						
payments.	Bank account number 0383939	Transit number institution	n number		number	.[].				
Electronic claim statement	By providing your email address, you will receive				1.6					
	Work email address hnapash@conte	Personal email address 1	<u>160thq</u> i	, unbas	shwgm	MIL COM				
9 Authorization a	and consent rage ("Coverage") under the Group Benefits plan	_								
true and complete to the provided by me, and/or portion of this Coverage I authorize Manulife to plan administration, aud or organization with Info plan administrator, insureach other and with Maron their behalf as if they deductions from my pay and administration, if my and administration, if my	Coverage may extend to my spouse and eligible a best of my knowledge. Lunderstand that as the my Dependents, in the future is true and complet, and future claims thereunder may be denied or collect, use, maintain and disclose personal informit, assessment, investigation, claim management rmation, including any medical and health profeser, investigative agency, and any administrators on ulife, its reinsurers and/or its service providers, for were signing it themselves, and to disclose and for my Group Benefits plan, if applicable. Lauthory SiN is used as my plan member certificate numbers.	e applicant, it is my responsibility to ensure e to the best of our knowledge. <u>I acknowle</u> terminated as a result of the provision of fa mation relevant to this application ("Information, underwriting and for determining plan eligationals, facilities or providers, professional of other benefits programs to collect, use, in for the Purposes. <u>I am authorized</u> by my Direceive their information, for the Purposes. prize the use of my Social insurance Numb ber. <u>Lagree</u> a photocopy or electronic versions.	that any fi dae and : dise, incom tion") for t ibility ("Pu regulatory naintain ar ependants I authoriz er ("SIN") on of this	irther verba agree that to plete, or mone the purpose rposes"). La bodles, an do exchange to consent or the purp authorization	I or written this Coverage isleading into so of Group to authorize a yemployer, ethis hilloring to this Authorize to this Authorize of ide in is valid.	statement ge or any formation. Benefits ny person group nation with norization, make ntification				
account ("Account") that me and any other financ <u>Lunderstand and agree</u> Payment(s). <u>Lalso unde</u> herein, and require my p Manulife into the Accour	Manulife to deposit all payments ("Payments") of I have identified on this form. I confirm that this ital institution I choose to name in the future; and the upon the deposit of any Payment(s) into the treatment and agree that Manulife may, at any time the treatment witten endorsement relating to future Part, to which I am not entitled, either by contract or by representatives of my estate.	direct bank deposit authorization applies to shall remain valid until revoked in writing to e Account, Manulife is fully discharged fron e and without prior notice, disconlinue the or ayment(s). I also hereby acknowledge an	the financy me, or me any further the deposit of the firm of the f	clat institution of duly author of llability was sit of Paymor at any Pay	on herein na orized repre- lith respect ent(s), as re- ment(s) ma	amed by esentative, to such equested de by				
If applicable, <u>Lauthorize</u> Manulife to correspond with me through the email address identified on this form regarding my Coverage, for the Purposes. <u>Lunderstand</u> such correspondence may contain information; and that the information is being sent in a manner that is not guaranteed as a secured means of communication. <u>Lagree</u> that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. <u>Lagree</u> should the email address identified on this form change that I am responsible for updating the email address maintained by Manulife. <u>Lunderstand</u> that if I do not wish to receive emails from Manulife, I can remove my email address online or by contacting the Customer Service Center.										
disability file. Access to a Manulife emplo persons to who persons author	nformation provided to or collected by Manulife in my Information will be limited to: nyees, representatives, reinsurers, and service pr om I have granted access; and ized by law, st access to the personal information in my file, a	oviders in the performance of their jobs;	·		·	ilth or				
Lacknowledge that mor	re specific details regarding how and why Manulif y and Privacy Information Package, available at v	e collects, uses, maintains, and discloses r	nv person:	al informatio		ound in				
Plan member signature	th napash	Da	te signed ((dd/mmm/y	(VVV) (0/1	<u>a/aoi7</u>				
10 Mailing instruc	tions Plan Member Administration Manufife Financial				****					

Plan Member Administration Manulife Financial PO BOX 11006, STN CENTRE-VILLE MONTREAL QC H3C 4T8



Produced on: MAR 21 2017 -

Print This Page

Revise Employee - Confirmation

Policy:

106790

Employee ID: 169

Effective Date: MAR 21 2017

The following enrollment information for HEATHER NAPASH has been successfully updated.

Employee Information:

Earnings/Frequency: \$45,000.00 Annually

If an "Employee Change Form" was completed for reasons other than a beneficiary change, keep the original signed form in a secure location. It may be required to support future benefit payments under your plan.

If the "Employee Change Form" includes a change in beneficiary the form must be signed and dated in ink and mailed to Great-West's Head Office. It may be required to support future benefit payments under your plan.

If the Beneficiary Information maintained on Great-West's system differs from the "Application for Group Coverage Form" or "Employee Change Form", the information on the forms will prevail.

Return to Maintain/Inquire on Employee Page

Return to Enrollment Home Page

View In-Force Premium and Taxes

[Help]

This site contains confidential information. It is intended for plan administration purposes only and may be viewed only by authorized personnel.

For inquiries on GroupNet, email us at GROUPNET Help Desk or call 1-800-665-2648.

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NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

HEATHER NAPASH

PLAN:

106790

ID:

169

DIVISION:

1

BENEFITS AT SEPTEMBER 02, 2014

BENEFIT	COVERA	.GE	
BASIC EMPLOYEE LIFE	\$	103,000	
BASIC DEPENDENT LIFE	INCLUD	ED	
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)	\$	103,000	
SHORT TERM DISABILITY	\$	495	MAXIMUM PER WEEK
LONG TERM DISABILITY	\$	2,145	MAXIMUM PER MONTH
CRITICAL ILLNESS	\$	30,000	
HEALTHCARE	FAMILY		
CONTACT - EMPLOYEE ASSISTANCE PROGRAM	FAMILY		

PLEASE TURN OVER

PLEASE NOTE:

This summary is not a legal document and is subject to change. If there is a difference between this summary and the provisions of the group policy, employee application form or change form, the forms and policy provisions will prevail. For more detailed information, please refer to your benefits booklet. If you find a discrepancy in this summary, please contact your plan administrator.

Great-West Life

BENEFICIARIES

NAMED BENEFICIARY

JESSIE C MATTINAS

RELATIONSHIP

REVOCABLE BENEFICIARY

PARENT

YES



*	STATUS
الإصريب	-

Great-West Life

APPLICATION FOR GROUP COVERAGE

ASSURANCE G-W COMPANY

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and sections 2 through 7 are to be completed by the plan member.

For GWL Head Office Use Only
GWL Certificate Number

section	ons 2 through 7 are to be comp	oleted by the plan member.				
	Plan Sponsor Section This section is to be	Plan number: 106790 Plan sponsor: NISHNAWBE	<u>-</u>	H SERVI		
	completed by the plan administrator.	Plan member ID:	o	ost centre (if applic		2044
	Please note the policy waiting period will be applied to the eligible date of employment.	Date of full-time employment: Mo Occupation: Admin . Assista		Day O & 		week hour
_	Plan Member Information This section is to be completed by the plan member. Please print clearly, in INK.	Plan member name (print): None last name Gender: Male Female Plan member mailing address: Street address: None Kensim City: None Boy Do you have a spouse (married, comm Do you have dependant children, including the common spouse) How many dependants in total, including the common spouse.	Date of birth: Month Province: On non-law or civil union specifing full time students of	ouse)?	Postal code: <u>P</u>	No
	Refusal of Benefits This section is to be completed by the plan member. Cross outs and/or corrections in this section must be initialed.	Note: Health and/or dental coverage benefits through your spouse's employer I understand the plan of group benefits Healthcare for myself and my Dentalcare for myself and my Spousal insurer's name: If you lose spousal coverage you m not apply within 31 days you and yo to Great-West Life to be covered. If Please see your plan administrator for	s offered to me, but I de dependants	ecline to participate of dependants only of dependants only Plan e within 31 days of e required to provice	in: 1 number: f loss of such co	overage. If you do ability acceptable
Bene	The original of this form will be i		if applicable. Ilclary designations must middle initial	Percent	rint clearly in INK. Date of birth month/day/year	Relationship to plan member
			miodie mittai	<u> 1001</u> 0 -		_mother
last na	<u> </u>	first name	middle initial			
last na		first name	middle Initial			
To be		s per the percentages indicated above, on equal shares to the survivor(s)	or			
you n form Note irreve	nay change this beneficiary des nay not change the designation #M6348 BIL. : Where Quebec law applies	signation at any time upon notice to Great or make certain changes to your coverage s and you have designated your mar box marked "Revocable", below.	ge under the plan withou	it the written consen	t of the beneficiar	y) please complete
,		s beneficiary designation at any time.	×-		- HA	
For C	≀uebec Applicants Only - Ber e paid to his/her tutor(s), unless	nefits payable under this plan to a benefic s a valid trust has been established for th	ciary who, at the time pa se benefit of the benefici	ayment is to be mad lary, by Will or by se	e, is a minor or la	icks legal capacity,

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to his/her tutor(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Great-West Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section. Before designating a trust, you should seek legal advice.

For All Other Applicants - If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing form #M6242 BIL. This appointment may not be suitable for all purposes. Before designating a trust, you should seek legal advice.

To be completed by the plan adr	ministrator	8 9			CaC.		
Plan number: 106 790	Plan member	r name: NIShna	mbe-Aski Lagal	Servi	Plan mem	ber ID:	
5. Dependant Information This section is to be completed Complete this section if the plif there are more than four de	by the plan member. Ian includes health and	d/or dental coverage a ch a separate list. Plea	ind you have not refused such co se print clearly, in INK.	verage for	your depe	endants in se	ection 3.
Spouse Information	first name	middle initial	What group benefits cove employer? HEALTHCARE Single Family Waived None S	DEN	es your sp FALCARE by Waived N	ı	through his/hei SIONCARE Family Waived None
Date of birth (month/day/year)		Gender Male Female □ □	Where applicable, benefit payments	will be coor	dinated betw	een this plan ar	nd your spouse's plan
Dependant Information			Date of birth month/day/year	Ge Male	nder Female	Full time student Yes	Disabled dependant Yes
hompson ast name	Ryder first name	middle initial	4006/19/2004				
hompson ast name	Karma first name	middle initial	09/12/2006				
1 hompson	first name	middle initial	8006)1111	abla			
ast name	first name	middle initial	-				
Great-West Life's commitment to privacy.	rights of access a Great-West Life. personal informat perform their dutie information may be information that we group benefits pla our relationship. F	nd rectification with r Great-West Life may ion in your file to Gr es, to persons to who be subject to disclosu e collect will be used n. This includes investor or a copy of our Priv luding with respect to	es of an organization authorized espect to the personal information use service providers located eat-West Life staff or persons and you have granted access, a reto those authorized under a perfor the purposes of determining stigating and assessing claims, a pacy Guidelines, or if you have a providers), write to Green especial control of the purpose	on in you within cauthorize and to per plicable I your eligit and creat	or file by some outside of by Great sons authorisist aw within bility for coing and manapout our about our sing and manapout our sin	ending a red Canada. Wat-West Life orized by later or outside (overage and aintaining responding in	quest in writing to le limit access to who require it to www. Your persona Canada. Persona administering the coords concerning
7. Authorizations and Declarations This section must be signed and dated in INK by the plan member.	I have read and u Information" on th I authorize: my plan spo under the pla Great-West I where it is re Great-West I administrator working with coverage and	nderstand and agree is form. nsor to deduct from an, if applicable; Life to use my social quired in the administ Life, any healthcare is of government be Great-West Life to ed to administer the pl	provider, my plan administrato mefits or other benefits progra exchange personal information, an.	st Life the rting purpor, other tims, other when ne	e plan me poses and insurance er organiz ecessary to	ember control as an iden or reinsura ations, or so determine	ibutions required tification number ance companies, service providers my eligibility for
	I agree that a pho	tocopy or electronic of formation given is truicents: I request the	and/or dependants, I confirm the copy of this <u>Authorizations and I</u> is, correct and complete to the I that this form be in English.	Declaration	ons section y knowled	n is as valid	
	Plan member sig	Je demand	le que ce formulaire me soit ren	nis en an	glais. /	July	17,201





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Employee Warning Notice

Employee Name: Heather Napash	Date: January 24, 2017			
Employee ID:	Job Title: TTP-Facilitator			
Manager: Carol Buswa	Department:			
	Type of Warning			
2 1. Verbal Warning by the Employee's				
3. Letter of Warning 4. S	uspension			
	Reason for Warning			
	enteeism			
	Event Details			
Description of Infraction:	Event Details			
	was not addressed or processed in the appropriate time -6 weeks lapsed service to family was compromised.			
Referral incident - In your role as facilitator it was your responsibility for activating the referral once you received it. Firstly, you received referral and entered it info into database November 25th it sat dormant and was not acted upon for two weeks. After Zelda received the phone call from Executive Director on December 7 she (Zelda) informed you about the referral where you sent it for approval. Referral was approved on that day and still no action took place until January 7, 2017. After lengthy review and discussion in resolving this matter, it was your responsibility to take immediate action on the referral.				
Plan for Improvement:				
- monitor client files on - once approved work of it (prioritizing high-low	detabase. on file immediately instead leaving ineferals) to avoid this situation			
Consequences of Further Infractions:				
	le 15 Nove en√ ya.			
Acknow	ledgement of Receipt of Warning			
By signing this form, you confirm that yo	ou understand the information in this warning. You also			
Employee: Hayash	Manager: Chuwa Date: Manager: Date:			





Employee Warning Notice

Employee Name: Heather Napash	Date: June 24, 2016
Employee ID:	Job Title: TTP Facilitator
Manager: Carol Buswa	Department: TTP
Type of Wa	rning
1. Verbal Warning by the Employee's Supervisor	2. Letter of Counsel
3. Letter of Warning 4. Suspension	5. Dismissal
Reason for V	Varning
☐ Tardiness/Leaving Early ☐ Absenteeism ☐ Substandard Work ☐ Rudeness to Clients ☐ Other:	☐ Violation of Company Policies /Coworkers ☐ Violation of Safety Rules
Description of Infraction: absent from 9-11:34 a.m. Failed to call	office 109 Mission Rd FWFN in before 9 a.m
Plan for Improvement: I plan to be on time; by Setting	my alarm clock-earlier.
Consequences of Further Infractions:	*
Next step -Letter of counsel	
A. C	
Acknowledgement of Re By signing this form, you confirm that you understand t	
confirm that you and your manager have discussed the this form does not necessarily indicate that you agree	warning and a plan for improvement. Signing

Manager: CBusura Date: June 24/16



Employee Warning Notice

Employee Information Employee Name: Heather Napash Date: September 4, 2014 Job Title: Assist. to Area Director Employee ID: Manager: Celina Reitberger Department: Type of Warning First Warning Second Warning Final Warning **Reason for Warning** Absenteeism Violation of Company Policies Tardiness/Leaving Early Violation of Safety Rules Rudeness to Clients/Coworkers Substandard Work See infraction below Other: Manager Approval Description of Infraction: Leaving premises without signing out Plan for Improvement: Don't do it again **Disciplinary Actions:** You will be sent home without pay – one full day Consequences of Further Infractions: Please see attached Whemo

Acknowledgement of Receipt of Warning

By signing this form, you confirm that you understand the information in this warning. You also confirm that you and your manager have discussed the warning and a plan for improvement. Signing this form does not necessarily indicate that you agree with this warning.

Francisco -	NA	Data
Employee	Manager	Date



TO:

Kirsten Rasevych, HR Clerk

Heather Napash, Assistant to Area Director

FROM:

Celina Reitberger, Executive Director

CC:

Personal Files

SUBJECT:

Unauthorized Leave

DATE:

October 9 2014

On September 4, 2014 I was looking for you to assist me.

I discovered that you and Heather Napash had left on a break without signing out. Sheba informed me that you stood at the sign-out sheet and she assumed you had signed out.

You returned after more than the allowable 15 minutes. Since there was no way to track your time a swift penalty was in order.

You were both sent home for 5 hours.

Further infractions could result in a 2 day suspension.

TALKING TOGETHER

Employee Performance Review



EMPLOYEE 1	INFORMATION						
Name Heather Napash				Employee ID	Employee ID		
Job Title Talking Together Facilitator				Date July 12	Date July 12, 2019		
Department	Talk Together Program			Manager	Carol Buswa		
Review Period	to						
RATINGS		1 - Door	2 = Fair	2 - Catiofactan	4 = Cood	5 = Excellent	
Job Knowled	ne	1 = Poor	Z = Fdir	3 = Satisfactory	4 = Good		
Comments	Heather is familiar with the pro uncertain she asks questions w	ogram and continue when needed.	s to demonstrate	her administrative skills	in processing clients	and work load. If she is	
Work Quality					✓ ·		
Comments	Heather displays good work et She applies herself promptly ar Facilitator-mediator	nic and demonstrat and efficiently but ne	es confidence as eeds to be more c	a professional in the adi ognizant of Circle proce	ministrative practices ss when working with	and processes of the job. n clients as a TTC	
Attendance/	Punctuality				✓ ·		
Comments	Heather demonstrates good at	tendance and is aw	are of the import	ance in this area.			
Initiative						✓	
Comments	Heather has demonstrated the tasks. If she is unsure about a During the TT Circle she was a	work related matte	r she calls the off	ice for assistance.			
Communicati	on/Listening Skills					✓	
Comments	new information. She is familia She was able to articulate the comfortable and at ease which	TT Circle very well	and demonstrated	d confidence throughout	r Program. The client and Circl	e participants were	
Dependability	Y					<i>₹</i>	
Comments	Heather continues to be reliable	e and accountable	in and out of the	office.			
Overall Ratin	g (average the rating numbers a	above)					
EVALUATIO	N						
ADDITIONAL C	that she serves.	She has established	ed a good work et		change. Heather is ar	ders of the communities a asset to the program and	
GOALS (as agreed upo employee and i		er - ADI	2 age (ou	irse.			
VERIFICATI	ON OF REVIEW						
you agree with	form, you confirm that you have this evaluation.	e discussed this revi	iew in detail with	your supervisor. Signing	n this form does not i	necessarily indicate that	
Employee Signa	ature Hnapash			Date Sep	6/19		
Manager Signat		Sq		Date Se	6/19 pt6/19,		