CINUP

EMPLOYEE CHANGE REQUEST

JG11-CU

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

Employer Name Nishnawbe-Aski Legal Services			Firm Number
Employee Name Doreen F. Stone			Certificate # 0063468931
☐ 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)			
Transfer Employee to Firm #			Effective Date of Transfer (YYYY/MM/DD)
Authorized Employer Signature			Date (YYYY/MM/DD)

EMPLOYEE INFORMATION CHANGE(S) (To be completed by employee - please print clearly in INK)

☐ Mailing Address	New Mailing Address (Number, Street, Apt. Number, City, Province, Postal Code)	
☐ Telephone Number	New Telephone Number (include area code)	
☐ Email Address	New Email Address	
☐ Name Change	From: To:	
☐ Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Common-Law - Date of Cohabitation (YYYY/MM/DD)	
	Date of Change (YYYY/MM/DD)	
☐ Status	☐ Change from Status to Non-Status ☐ Change from Non-Status to Status	Status Registry Number (10 digits)

COVERAGE CHANGE(S) (To be completed by employee - please print clearly in INK)

☑ Add Coverage	☑ Extended Health Care ☑ Dental Care Effective Date (YYYY/MM/DD) 2024/08/02	
	Were you or your dependents covered under a spousal plan? ☐ No ☐ Yes, until (YYYY/MM/DD)	
☐ Cancel Coverage	You may cancel 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. Do you or your dependent(s) have other coverage? ☐ No ☐ Yes	
	Name of Insuring Company	
	Effective Date (YYYY/MM/DD)	Policy Number
☑ Change Coverage	☐ to Single coverage ☑ to Family Coverage	
	Reason for Change (Where applicable, complete **DEPENDENT INFORMATION CHANGE(S)** on page 2): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Birth / Adoption / Adopt by custom ☐ Common-Law - Date of Cohabitation (YYYY/MM/DD) _____ A Common Law spouse is only eligible for coverage after 12 consecutive months of co-habitation.	
	☐ Date of loss of duplicate coverage (YYYY/MM/DD)	
	☑ Other (please specify) adult children under my care returning to school	
	What benefit coverage do your spouse/dependents have through another insurer? Extended Health Care: ☐ Single ☑ Family ☐ None Are you coordinating benefits? ☐ Yes ☐ No Dental Care: ☐ Single ☑ Family ☐ None Are you coordinating benefits? ☐ Yes ☐ No	
	Name of Insuring Company	

Continued Next Page

CINUP

EMPLOYEE CHANGE REQUEST

JG10-CU

DEPENDENT INFORMATION CHANGE(S) (To be completed by employee - please print clearly in INK)

	Date of Change (YYYY/MM/DD)	First Name & Initial (last name if different)	Relationship	Date of Birth (YYYY/MM/DD)	Status	Gender
☑ Add ☐ Remove ☐ Change	08/0224	Cameron Stone	Son	2001/10/04	☐ Non-Status ☑ Status	☐ Female ☑ Male ☐ Other Expression ☐ Undisclosed
☑ Add ☐ Remove ☐ Change	08/02/24	Carson Stone	Son	2003/05/24	☐ Non-Status ☑ Status	☐ Female ☑ Male ☐ Other Expression ☐ Undisclosed
☐ Add ☐ Remove ☐ Change					☐ Non-Status ☐ Status	☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed

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)

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.

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** August 2, 2024