





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

	The second secon								
Employer Name N. s	hambe Legal Services C	orgitim	Firm N	umber					
	MALLO RUSSIAN		Certificate # CU 00634 70505						
Occupation Change	New Occupation		Effectiv	ve Date (YYY/MM/DD) ZoZ	2/06/19				
Salary Change	Earnings	☐ Annually	Weekly	Bi-Weekly	# Hours/Week				
Effective Date of Salary Change (YYYY/MM/	DD)		_ Semi-Λ	1,000					
Transfer Employee to Fi	rm#	Effective	Date of Tr	ransfer (YYY/MM/DD)					
Authorized Employer Signature	ladite	Sus		Date (YYY/MM/DD) 2322/06/20					
EMPLOYEE INFORM	ATION CHANGE(S) (To be co	ompleted by employee	please pr	rint clearly in INK)					
Mailing Address	New Mailing Address (Number	r, Street, Apt. Number,	City, Pro	vince, Postal Code)					
Telephone Number	New Telephone Number (inclu	de area code)							
Email Address	New Email Address								
Name Change	From:		To:						
Marital Status	Single Married Widowed Separated Divorced Common-Law - Date of Cohabitation								
	Date of Change (YYYY/MM/DD)								
Status	Change from Status to Non-S	tatus 🗌 Change from N	on-Status t	to Status Registry N	umber (10 digits)				
COVERAGE CHANG	E(S) (To be completed by emplo	yee - please print clearf	y in INK)	-					
Add Coverage	Extended Health Care	Dental Care Effective I	Date (YYY	/MAN/DD)					
	Were you or your dependents co	vered under a spousal plan	? No	Yes, until (YYYIMW/DD)					
Cancel Coverage	You may cancel Extended Heal ONLY if you are covered for si Do you or your dependent(s) h	milar benefits under you	ur spouse'	Benefits for yourself and your dependent(s) spouse's plan.					
	Name of Insuring Company								
	Effective Date (YYYY/MW/DD)		P	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 (YYY/MM/DD) A Common Law spouse is only eligible for coverage after 12 consecutive months of co-habitation.								
			rave monas	CO CO-Habitation.					
	Date of loss of duplicate cover	age (YYYYIMM/DD)							
	Other (please specify)								
	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	WW. C.							



CINUP EMPLOYEE CHANGE REQUEST



	Date of Change (YYY/MM/DD)	First Name & Initial (last name if different)		Relationship		Birthdate (YYYY/MM/DD)		Status	Gender
Add Delete Change	Z022/06/12	CARTER G. HEI	NO	Son		2015/08/13		Non-Status ☐ Status	X.M □ F
Add Delete Change	2022/06/13	LILLA E.R. Rus	MAK	DANGHTER		2022/04/03		☐ Non-Status Status	□ M
Add Delete Change								☐ Non-Status	□ M □ F
BENEFIC	IARY DESIGNAT	ION – Please print clearly in I	NK (cros	sed out or	revised info mus	st be in	nitialled by en	nployee)	
First & Last Name		Middle Initial		Date of Birth (YYY/MM/DD)		% of benef	fit Relat	ionship	
Addition	nal Beneficiaries	Contingent Beneficiaries	(Seconda	ry benefic	ciary if the above	bene	ficiary is dec	eased)	
rustee/Ad	ministrator Design	ation							
f the benef peneficiary	ficiary is under the a under this policy. T	ge of majority, I appoint the t he trustee/administrator shall	discharge	the Insu	rer for the amou	nt pai	d. I authorize	ount payable t	o a minor dministra
f the benef seneficiary o spend all	ficiary is under the a under this policy. To or part of the amou	ige of majority, I appoint the t	discharge	port or ed	rer for the amou	nt pai	d. I authorize	ount payable t the trustee/a	o a minor dministra
f the benef peneficiary to spend all Full Name	ficiary is under the a under this policy. The or part of the amou	ge of majority, I appoint the t he trustee/administrator shall	discharge or the sup	pport or ed	rer for the arnou ducation of the r elationship	nt pai ninor.	d. I authorize	the trustee/a	o a minor dministra
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