



# CINUP EMPLOYEE CHANGE REQUEST



JG11-CU

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

Employer Name <u>Nishnab, Legal Services Corporation</u>		Firm Number	
Employee Name <u>DONALD RUSMAN</u>		Certificate # <u>CU 00634 70505</u>	
<input type="checkbox"/> Occupation Change	New Occupation	Effective Date (YYYY/MM/DD) <u>2022/06/19</u>	
<input type="checkbox"/> Salary Change	Earnings	<input type="checkbox"/> Annually	<input type="checkbox"/> Weekly
		<input type="checkbox"/> Monthly	<input type="checkbox"/> Semi-Monthly
		<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Hourly
Effective Date of Salary Change (YYYY/MM/DD)		# Hours/Week	
Transfer Employee to Firm #		Effective Date of Transfer (YYYY/MM/DD)	
Authorized Employer Signature <u>[Signature]</u>		Date (YYYY/MM/DD) <u>2022/06/20</u>	

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

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

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

<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care Effective Date (YYYY/MM/DD)	
	Were you or your dependents covered under a spousal plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, until (YYYY/MM/DD)	
<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	Name of Insuring Company	
	Effective Date (YYYY/MM/DD)	Policy Number
<input type="checkbox"/> Change Coverage	<input type="checkbox"/> to Single coverage <input type="checkbox"/> to Family Coverage	
	Reason for Change (Where applicable, complete DEPENDENT INFORMATION CHANGE(S) on page 2):	
	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Birth / Adoption / Adopt by custom <input type="checkbox"/> Common-Law - Date of Cohabitation (YYYY/MM/DD) _____ <small>A Common Law spouse is only eligible for coverage after 12 consecutive months of co-habitation.</small>	
	<input type="checkbox"/> Date of loss of duplicate coverage (YYYY/MM/DD)	
	<input type="checkbox"/> Other (please specify)	
	What benefit coverage do your spouse/dependents have through another insurer?	
	Extended Health Care: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> None	Are you coordinating benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dental Care: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> None	Are you coordinating benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Insuring Company	



# 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	Birthdate (YYYY/MM/DD)	Status	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input checked="" type="checkbox"/> Change	2022/06/18	CARTER G. HEINO	SON	2015/08/13	<input checked="" type="checkbox"/> Non-Status <input type="checkbox"/> Status	<input checked="" type="checkbox"/> M <input type="checkbox"/> F
<input checked="" type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	2022/06/18	LILIA E.R. RUSNAK	DAUGHTER	2022/04/03	<input type="checkbox"/> Non-Status <input checked="" type="checkbox"/> Status	<input type="checkbox"/> M <input checked="" type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change					<input type="checkbox"/> Non-Status <input type="checkbox"/> Status	<input type="checkbox"/> M <input type="checkbox"/> F

### BENEFICIARY DESIGNATION - Please print clearly in INK (crossed out or revised info must be initialed 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 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 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](http://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 2022/06/20