CINUP INDIVIDUAL APPLICATION FOR GROUP INSURANCE

Please mail the original completed in ink to MGI Financial Inc., and keep a photocopy for your records.

OFFICE USE ONLY
CERT #

EMPLOYER: ABC COMPANY

SMITH	BOBBY	ALBERT
Applicant's Surname	First Name	Middle Name
01/03/70	YES	M
Birth date(mm/dd/yy)	Status: Y / N	Sex: M / F

123 MARKET ST
Address: - Street/Box Number

WINNIPEG	MB	ZOZ OZO
City or Town	Province of Residence	Postal Code

(123) 456-7890 — Home Telephone Number
999 999 999 — Social Insurance Number

Dependents age 21 and over must be full-time students. If applicable, please complete the Confirmation of School Attendence form.

	FIRST NAME	LAST NAME (if different)	Sex M/F	STATUS **Yes/No**	Birth date **(mm/dd/yy)**
Spouse or Common Law	EDNA		F	YES	01/05/72
Dependent Children	MARY	JONES	F	YES	04/06/01
					/ /
					/ /
					/ /
					/ /

EMPLOYEES MUST ENROLL ACCORDING TO THEIR TRUE FAMILY STATUS, LISTING ALL ELIGIBLE DEPENDENTS

TYPE OF COVERAGE: SINGLE ☐ FAMILY ☑

I apply and authorize payroll deductions, if required, for all Benefits for which I become eligible.

WAIVER: I am insured for ☐ Extended Health Care (EHC) ☐ Dental under my spouse's group insurance and therefore do not require to be insured for these benefits.

COMPLETE THE FOLLOWING IF WAIVING EHC AND/OR DENTAL COVERAGE:

Spouse's Insurance Carrier(s): ______________________

Spouse's Group Policy number(s): ______________________

BENEFICIARY: I reserve the right to change the beneficiary at any time, unless otherwise provided by contract.

Full Name	Date of Birth (mm/dd/yy)	Relationship to employee	Proportion
EDNA SMITH	01/05/72	WIFE	75 %
MARY JONES	04/06/01	DAUGHTER	25 %
			%
			%
			%

Please indicate relationship to beneficiary. If a minor indicate date of birth and assign trustee below. If additional space is required, please attach a separate page.

TRUSTEE: EDNA SMITH, my WIFE if living, is hereby appointed trustee to receive and disburse any moneys payable to a child aforesaid of minority. Any payment made to said trustee shall discharge the company to the extent of such payment.

I certify that 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.

I agree to the Authorization and Consent on the reverse side of this form. If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

Applicant's Signature: Bobby Smith **Date:** 04/01/01

TO BE COMPLETED BY THE PLAN ADMINISTRATOR:

Date of Employment (permanent): 04 / 01 / 01 (MM / DD / YY) Effective Date of coverage: 07 / 01 / 01 (MM / DD / YY)

☑ New Enrollment ☐ Reinstatement Number of hours worked per week: 35

Job Title: WORKER Earnings: $ 13.75 per HR

In order to protect the viability of these plans, employees enrolled in Supplementary Health Plans are not permitted to opt-out while still employed (except in the event of recently obtained duplicate coverage).

Employer Signature: Plan Administrator Date: 04/04/01

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by MGI Financial 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 services 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 that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits or consenting or refusing to consent to its disclosure. For additional information regarding MGI Financial Inc.'s Group Benefits privacy policy I can contact MGI Financial at 204-786-0324 or privacy@mgiwealth.com should I have questions as to the collection, use or disclosure of my personal information.