CINUP INDIVIDUAL APPLICATION FOR GROUP INSURANCE
CHIEF & COUNCIL AND/OR APPOINTED OFFICIAL

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

Applicant's Surname	First Name	Middle Name
SMITH	BOBBY	ALBERT

Birth date(mm/dd/yy): 01/03/70 Status: Y / N: YES Sex: M / F: M

Address: - Street/Box Number: 123 MARKET STREET

City or Town: WINNIPEG Province of Residence: MB Postal Code: Z0Z0Z0

Home Telephone Number: (555) 123-4567 Social Insurance Number: 000 000 000

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

Elected Date: 04/01/01 (MM / DD / YY) Effective Date of coverage: 04/01/01 (MM / DD / YY)

☑ New Enrollment ☐ Reinstatement Job Title: CHIEF

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