

CINUP ENROLLMENT APPLICATION CHIEF & COUNCIL AND/OR APPOINTED OFFICIAL



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

For office use only

Effective Date	Certificate #
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1

To be Completed by Employer (Please print clearly in INK)

Employer Name	
Employer Code	Date Elected (MM/DD/YYYY)
Job Title	
Authorized Signature	Date (MM/DD/YYYY)

2

Employee Information (To be completed by the employee - Please print clearly in INK)

Applicant's Name (Last) (First) (Initial)		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Status <input type="checkbox"/> Non-Status
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common-Law: Date Started Living Together (MM/DD/YYYY) <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Address (Number, Street, Apt. Number)		City/Town
Province	Postal Code	Daytime Phone (_____) _____

3

Dependent Information - List your spouse and children below (please print clearly in INK)

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

	First Name	Last Name	Status	Date of Birth MM/DD/YYYY	Gender	Relationship
Spouse or Common Law			<input type="checkbox"/> Status <input type="checkbox"/> Non-Status		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent Children			<input type="checkbox"/> Status <input type="checkbox"/> Non-Status		<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> Status <input type="checkbox"/> Non-Status		<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> Status <input type="checkbox"/> Non-Status		<input type="checkbox"/> M <input type="checkbox"/> F	
			<input type="checkbox"/> Status <input type="checkbox"/> Non-Status		<input type="checkbox"/> M <input type="checkbox"/> F	

4

Coverage Requested

You may waive 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. You may apply at a later date for benefits you have waived but certain restrictions may apply. *Please see your Plan Administrator for details*

Extended Health Care (check one ONLY)

- Single
- Family
- Waive: Name of Other Insurer _____

Dental Care (check one ONLY)

- Single
- Family
- Waive: Name of Other Insurer _____

Beneficiary Designation - Please print clearly in INK (if information is revised, have employee initial)

I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan. (If you designate more than one beneficiary, please indicate what portion of the benefit each individual is to receive and ensure the total adds up to 100%)

First Name	Last Name	Initial	Relationship	Date of Birth MM/DD/YYYY	% of Benefit Must equal 100%

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If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support of education of the minor.

Trustee Name _____ Relationship _____

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 the 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 of 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.

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.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

Signature of Applicant _____ Date _____