

**NOTICE OF COVERAGE CHANGE**  
**CINUP Group Insurance & Pension Plan**



Employer's Name: \_\_\_\_\_ Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yr

Employee's Name: \_\_\_\_\_

Group Insurance Certificate # \_\_\_\_\_  Pension Plan Certificate # \_\_\_\_\_

**1. COVERAGE CHANGES**

- I am **ADDING**       Single /  Family       Extended Health Care and/or  Dental Care  
Reason: \_\_\_\_\_
- I am **DELETING**       Single /  Family       Extended Health Care and/or  Dental Care  
Reason: \_\_\_\_\_
- I am **CHANGING**       Single to Family  Family to Single  
Reason: \_\_\_\_\_

**2. DEPENDENT INFORMATION - ADD / DELETE**

	First Name & Initial (Last Name if Different)	Sex M/F	Date of Birth			Status Yes/No	A - Add D - Delete
			Mo.	Day	Yr.		
Spouse							
Child							
Child							

**3. MARITAL CHANGE**

Legal Marriage  Common Law\*\*  Divorce If you are waiving coverage because your spouse has Health or Dental Coverage which will cover you as well, please indicate the company in which you will be covered through:

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_      \*\*Date of cohabitation if Common Law \_\_\_\_/\_\_\_\_/\_\_\_\_

Note: Common Law requires 12 months cohabitation before coming effective.

**4. CHANGE OF NAME**

Previous Name: \_\_\_\_\_ New Name: \_\_\_\_\_

Reason for Change: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employee Former Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Employee Present Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Note: Please provide proof of change - i.e. Copy of Marriage Certificate

**5. ADDRESS CHANGE**

Address (Street & No) \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

I certify that all information contained herein is correct. I also 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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY**       Group Insurance       Pension Plan - Policy No. \_\_\_\_\_

## **AUTHORIZATION AND CONSENT**

I understand that the personal information provided herein as well as any other personal information currently held 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 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](mailto:privacy@mgiwealth.com) should I have questions as to the collection, use or disclosure of my personal information.

## NOTICE OF COVERAGE CHANGE FORM EXPLANATION

*Please note: If you are reporting a Termination, or Change of Beneficiary, or Salary/Occupation change they must be completed on a separate form.*

The information at the top of the form identifies the employee requesting the change and must be completed for any and all changes. You will have **31 days** from the date the change occurred to notify us.

If you are now **MARRIED**, please complete the following sections:

- Coverage Changes - adding your spouse and moving from single to family or deleting extended health care and dental if your spouse has coverage elsewhere
- Dependent Information - adding your spouse's information
- Marital Change - date the marriage occurred
- Change of Name - if applicable
- Please accompany this form with a copy of your Marriage Certificate

If you have become **COMMON-LAW**, please complete the following sections:

- Coverage Changes - adding your spouse and moving from single to family
- Dependent Information - adding your spouse's information
- Marital Change - date you began living together

*Please note that there is a one year waiting period from the date of cohabitation before your common-law spouse will be added to the plan.*

If you **HAD OR ADOPTED A CHILD**, please complete the following sections:

- Dependent Information - adding your child's information

If you got a **DIVORCE**, please complete the following sections:

- Coverage Changes - deleting your spouse and moving from family to single if you have no other dependents
- Dependent Information - deleting your spouse's information
- Change of Name - if applicable (a copy of the proof of name change is required)
- Submit a Certificate of Divorced, as required by the Insurance Companies.