CINUP

COMMUNITY MEMBER PLAN ENROLMENT APPLICATION

JG10-CU

Each individual member must submit an Application, including Community Members under the age of 18.

MEMBER INFORMATION (To be completed by the member or guardian)

Community or First Nation Name			
Member Name LAST FIRST INITIAL			
Gender ☐ Female ☐ Male ☐ Other Expression ☐ Undisclosed	Date of Birth (YYYY/MM/DD)	Email Address	
Mailing Address (Number, Street, Apt. Number or P.O. Box)		Phone ( )	
City		Province	Postal Code
Provincial Health Care Number		☐ Status ☐ Non Status	Status Registry Number

☐ I certify that I am a member of the above-named Community or First Nation, a resident of Canada, and enrolled in a Provincial Health Care Plan.

GUARDIAN INFORMATION – Appointment of Guardian (if member is under 18)

Note benefits cannot be paid directly to a child under the age of 18. A guardian or trustee would have to be appointed to receive these benefits. If a guardian is not named, payments could be delayed.

Guardian Name LAST FIRST INITIAL			
Guardian Relationship	Date of Birth (YYYY/MM/DD)	Email Address	
Mailing Address (Number, Street, Apt. Number or P.O. Box)		Phone ( )	
City		Province	Postal Code

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 CINUP 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.

I accept the terms of the Privacy Policy, and I understand that I can refer to www.cinup.ca or contact the CINUP Privacy Compliance Officer for more specific information about collection and use of my personal information and my questions about privacy. I acknowledge that I have reviewed the Privacy Policy. The non-exhaustive list of sources that personal information can be collected from and disclosed to includes myself, medical and health professionals, facilities or providers, insurance companies, or other organizations/persons.

I understand the personal information will be kept confidential and secure. I understand I may revoke my consent at any time. I understand that I have the right to request access to the relevant personal information that CINUP holds in my file, and to have this information corrected or deleted as necessary. 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.

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 the above-named Community or First Nation.

I understand this plan is intended to be payer of last resort and agree to exhaust all other coverages first before I submit claims.

I certify the above information is correct and I agree to the conditions of the group agreement between the above-named Community or First Nation and CINUP.

Signature of Member or Guardian _____ **Date** _____