



APPLICATION FOR GROUP COVERAGE

Please print clearly and complete both sides of this form, in INK. Section 1 is to be completed by the plan administrator and section 2 through 7 are to be completed by the plan member.

1. Plan Administrator Section

This section is to be completed by the plan administrator.

Please note the policy waiting period will be applied to the eligible date of employment.

New Application Reinstatement - Plan member returned to work on: Month _____ Day _____ Year _____
 Reason: _____

Employer: _____ FNIS Plan ID #: _____
 Plan member: _____ Annual salary: _____
 Employment start date: Month _____ Day _____ Year _____ Occupation: _____
 Plan member province of employment: _____ Plan member province of residence: _____

Full Time Employee - all employees working over 15 hours per week annual on average (excludes Chief/Councillors/Senators)

(THE FOLLOWING ARE AVAILABLE, IF EMPLOYER HAS ELECTED THIS COVERAGE)

Chief/Councillors/Senators (Life & AD&D) Elders Board Regular Seasonal
 Chief/Councillors/Senators (Term Employees) Permanent Seasonal Permanent Casual/Temporary Term

Plan Administrators signature: _____ Date: _____

2. Plan Member Information

This section is to be completed by the plan member.

Please print clearly, in INK.

Gender (as shown on Provincial Health Card): Male Female Date of birth: Month _____ Day _____ Year _____

Plan members mailing address:

Street address/Box number: _____ City: _____
 Province: _____ Postal Code: _____ Phone number: _____

Status: Yes No 10 Digit Treaty Number: _____
 Name of Band: _____

3. Dependant Information

This section is to be completed by the plan member or their designate.
 If there are more than five dependants, please attach a separate list, please print clearly, in INK.

What group benefits coverage does your spouse have through his/her employer? Where applicable, benefit payments will be coordinated between this plan and your spouse's plan.

EXTENDED HEALTH: Single Family Waived None **VISION:** Single Family Waived None **DENTAL:** Single Family Waived None

Spousal Insurer's name: _____ Spouse's Plan number: _____

Spouse / Dependant Information

Relationship	last name	first name	middle initial	Date of birth month/day/year	Status		10-digit treaty #	Gender		Full-time Student Yes	Disabled Depend.
					Yes	No		(M)	(F)		
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This section for FNISLP use only:

EH.	Eff.	LT.	Eff.
VIS.	Eff.	ST.	Eff.
DEN.	Eff.	LIFE	Eff.

To be completed by the plan administrator

FNIS Plan ID number: _____

Plan member name: _____

4. Opting Out and/or In of Extended Health & Vision and/or Dental Benefits

This section is to be completed by the plan member.

Note: Extended Health & Vision and/or Dental coverage can only be refused if you and/or your dependants are covered by duplicate group benefits through your spouse's employer. I understand the plan of group benefits offered to me, but I decline to participate in:

Extended Health & Vision for myself and my dependents my dependents only
Dental for myself and my dependents my dependents only

If your spouse loses their employer's health coverage, you must apply for coverage under this plan effective the date of loss of spousal coverage. Premiums will be charged from the date of that lost of coverage.

5. Beneficiary Designation

This section is to be completed by the plan member. This section must be completed to designate a beneficiary for your life benefits.

The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed.

If no Percentage is allocated; it will be paid out in equal shares (any rounding will be applied to the first beneficiary)

If there are more than five beneficiaries, please attach the beneficiary addendum form. Please print clearly, in INK. **DO NOT USE WHITE OUT**

Listed beneficiary is revocable.

Beneficiary's name(s)	Percent Allocated	Date of birth month/day/year	Relationship to plan member
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____
last name first name middle initial	_____	_____	_____

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a trustee/administrator below. If you are designating a trustee/administrator, we recommend you consult with a legal advisor.

Trustee: _____
last name first name middle initial Relationship to plan member

6. Privacy

This section explains First Nations Insurance Services Limited Partnership's commitment to privacy

Protecting Your Personal Information

At First Nations Insurance Services Limited Partnership (hereinafter referred to as FNISLP), we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of FNISLP or the offices of an organization authorized by FNISLP. You may exercise certain right of access and rectification with respect to the personal information in your file by sending a request in writing to FNISLP. We limit access to personal information in your file to FNISLP staff or person(s) authorized by FNISLP who require it to perform their duties, to person(s) to whom access has been granted, and to person(s) authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims and creating and maintaining records concerning our relationship.

7. Authorization and Declaration

This section must be signed and dated in INK by plan member & witness.

Witness cannot be a beneficiary.

I hereby apply for coverage under the group benefits plan issued by First Nations Insurance Services Limited Partnership. I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form. I authorize:

- My plan sponsor to deduct from my pay and remit to FNISLP the plan members contributions required under the plan, if applicable;
- FNISLP, any healthcare provider, my plan administrator, other Insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with FNISLP to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

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

I agree that a photocopy or electronic copy of this Authorization and Declaration section is as valid as the original.

Plan member signature: _____ **Date:** _____

Witness signature: _____