



# GROUP COVERAGE DATA CHANGE

Please print clearly and complete both sides of this form, in INK.

**1. What information are you Changing?**

- Salary and/or Occupation Change:  Yes  No (Complete Section 2 and sign in Section 9)
- Name Change:  Yes  No (Complete Section 3 and sign in Section 9)
- Address Change:  Yes  No (Complete Section 4 and sign in Section 9)
- Dependant Information Change:  Yes  No (Complete Section 5 and sign in Section 9)
- Opting In and/or Out of Benefits:  Yes  No (Complete Section 6 and sign in Section 9)
- Change Beneficiary Information Change:  Yes  No (Complete Section 7 and sign in Section 9)

**2. Plan Administrator Section**

This section is to be completed by the plan administrator

Employer: \_\_\_\_\_ FNIS Plan ID #: \_\_\_\_\_

Plan member: \_\_\_\_\_

Salary: \_\_\_\_\_ Effective date of Salary change: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Occupation: \_\_\_\_\_ Effective date of Occupation change: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Plan Administrators signature: \_\_\_\_\_ Date: \_\_\_\_\_

**3. Plan Member Name Change**

From: \_\_\_\_\_ To: \_\_\_\_\_

last name first name middle initial last name first name middle initial

Effective date of Name change: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**4. Plan Member Address Change**

**Plan members mailing address:**

Street address/Box number: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone number: \_\_\_\_\_

**5. Dependant Information**

This section is to be completed by the plan member or their designate.  
 This section must be completed if you are adding, or deleting a dependent, or updating dependent information.  
**If there are more than five dependents, please attach a separate list, Please print clearly, in INK.**

Effective date of change: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ To:  Single coverage  Family coverage

Reason:  Birth of a child  Divorce  Marriage  Cohabitation  other \_\_\_\_\_

**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

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

To be completed by the plan administrator

FNIS Plan ID number: \_\_\_\_\_

Plan member name: \_\_\_\_\_

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

Once you opt out of your coverage, you are not able to opt back into coverage unless your spouse loses their coverage.

**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

Spousal Insurer's name: \_\_\_\_\_ Spouse's Plan number: \_\_\_\_\_

**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 loss of coverage.**

**Note:** You may apply to be enrolled for group coverage if your spouse has lost group benefits coverage through his/her employer.

Effective date of loss of coverage through spousal plan: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Indicate the Benefit(s) no longer covered under the spousal plan: Extended Health:  Vision:  Dental:

**7. 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 four 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 _____	_____	_____	_____

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

**8. 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 include investigating and assessing claims and creating and maintaining records concerning our relationship.

**9. 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:** \_\_\_\_\_