FIRST NATIONS INSURANCE SERVICES LIMITED PARTNERSHIP

EMPLOYEE DATA CHANGE FORM

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 Sections 2, 3, 7 and sign in Section 11)
Transfer Between Groups:	☐ Yes	☐ No	(Complete Sections 2, 3, 7 and sign in Section 11)
Name Change:	☐ Yes	☐ No	(Complete Sections 2, 4, 7 and sign in Section 11)
Address Change:	☐ Yes	☐ No	(Complete Sections 2, 5, 7 and sign in Section 11)
Dependent Information Change:	☐ Yes	☐ No	(Complete Sections 2, 6, 7 and sign in Section 11)
Opting In and/or Out of Benefits:	☐ Yes	☐ No	(Complete Sections 2, 7, 8 and sign in Section 11)
Beneficiary Information Change:	☐ Yes	☐ No	(Complete Sections 2, 7, 9 and sign in Section 11)

Effective date of change: Month __________________ Day _________Year __________

2. Plan Administrator or Plan Member to complete

Employer: ______________________________ FNIS Plan ID #: ______________________

Plan member: ______________________________ Blue Cross Member ID #: ______________________

3. Plan Administrator Section

This section is to be completed by the plan administrator

Salary: ____________________________ Occupation: ______________________________

Transfer from: ______________________ Transfer to: _________________________

Plan Administrators signature: ______________________________ Date: ______________________

4. Plan Member Name Change

From: ______________________________ To: ______________________________

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

5. Plan Member Address Change

Plan members mailing address:

Street address/Box number: ______________________________ City: ______________________________

Province: ___________________ Postal Code: ___________________ Phone number: ______________________________

6. Dependent 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.

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.

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

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

Spouse / Dependent Information

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

7. Plan Administrator or Plan Member to complete

Employer: _____ FNIS Plan ID #: _____

Plan member: _____ Blue Cross Member ID #: _____

8. 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 & Vison and/or Dental coverage can only be refused if you and/or your dependents 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 lost 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: ☐

9. 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

10. 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.

11. 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 dependents, 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: _____