CINUP

# ENROLMENT APPLICATION - WESTBANK FIRST NATION

JG10-CU

WESTBANK FIRST NATION

**Westbank First Nation Members Only** – Each individual member must submit an Application

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## MEMBER INFORMATION (To be completed by the member or guardian – Please print clearly in INK)

| Member Name LAST | FIRST | INITIAL |
|---|---|---|
| | | |

| Gender ☐ Male ☐ Female | 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 Number 601 ___ ___ ___ ___ ___ ___ ___ | |

☐ I am a WFN Member, a resident of Canada and enrolled in a provincial Health Care Plan.

| FOR OFFICE USE ONLY | Date Received | Certificate # |
|---|---|---|

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

Note that 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 | | Email Address |
|---|---|---|
| Mailing Address (Number, Street, Apt. Number or P.O. Box) | | Phone ( ) |
| City | Province | Postal Code |

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### Authorization and Consent

I understand that 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.

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 the 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 JG Benefits Inc's group benefits privacy policy I can refer to the Privacy & Terms of Use section of jgbenefits.ca should I have questions as to the collection, use or disclosure of my personal information.

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 Westbank 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 that the above information is correct and I agree to the conditions of the group agreement between WFN and JG Benefits Inc.

**Signature of Member or Guardian** ______________________________ **Date** ________________