

NEBS ENROLMENT FORM ELECTED & APPOINTED OFFICIALS

Ph: (867) 873-4965 Fax: (867) 873-5801

ALL ELECTED OFFICIALS AND/OR APPOINTED DIRECTORS MUST COMPLETE AND SUBMIT THIS ENROLMENT FORM WITHIN 31 DAYS OF THE START DATE OF THEIR TERM IN OFFICE. IF THE FORM IS NOT RECEIVED WITHIN THIS TIMELINE MEDICAL UNDERWRITING WILL BE REQUIRED AND COVERAGE MAY BE DELAYED OR DENIED.

PLEASE PRINT CLEARLY IN BLUE INK AND RETURN ORIGINAL SIGNED FORM TO THE NEBS OFFICE.

PERSONAL INFORMATION				
Last Name:				
First Name:				
Mailing Address:				
Community/City:	Territory/Province:	Postal (Postal Code:	
Birth Date: dd / mm / yyyy				
Email:	Phone:			
Employer Name:				
INSURANCE PLAN BENEFICIARY INFORMATIO	ON			
Your insurance plan will provide benefits to beneficiary, death benefits will be paid to you	•	•	•	
beneficiary, death benefits will be paid to you I hereby name my beneficiary(ies) for Life In follows in equal shares unless otherwise prov	ur estate. If more space is required, some surance and Accidental Death, Discovided below:	please copy this	page. mberment Insurance a	
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CERTIFICATION

Comments:

<u>NORTHERN EMPLOYEE BENEFITS SERVICES PRIVACY STATEMENT</u>: Northern Employee Benefits Services (NEBS) is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses while conducting business.

<u>IMPORTANT:</u> The information you have submitted on this form will be used to determine future benefits. If for any reason information changes, the Information Changes Form should be completed.

I hereby apply for plan coverage and authorize the remittance to NEBS of any required contributions. I hereby authorize NEBS and their Insurance Underwriters, or any other person or organization having any relevant information to release and exchange any and all information necessary for the purposes of determination of plan eligibility for benefits and administration. I acknowledge the use of my Social Insurance Number (SIN) for the purposes of tax reporting, identification and administration of any benefits. I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

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of any benefits. I declare the as valid as the original.	nat the information provided is tr	rue, complete and accurate. A	ny copy of this authorization shall be		
as valid as the original.					
Elected or Appointed Office	cial Signature	Date			
	THIS SECTION IS TO BE C	OMDI ETED BY THE EMDI	OVED		
	THIS SECTION IS TO BE C	OMPLETED BY THE LIMITE	LOTER		
Please print clearly in <u>BL</u>	<u>UE INK</u>				
EMPLOYER INFORMATION	N				
Employer Name:					
	Last Name, First Name				
ELECTED OFFICIAL INFORM	MATION				
Elected Official Name: _		Last Name, First Name			
Term Start Date:	dd / mm / yyyy	Term End Date:	dd / mm / yyyy		
Position Title:					
EMPLOYER CERTIFICATION	M				
•			to the best of my knowledge, an		
Eligible Elected Official to	or NEBS Elected and Appointed	Officials Plati Coverage.			
		Last	Name, First Name		
Employer Signature (Perso	on with Signing Authority)		(Person with Signing Authority)		
THIS SECTION IS TO BE COMPLETED BY NEBS					