



**CSI-CANADA INSURANCE PLAN AND TRUST  
RETIREE ENROLMENT AND CHANGE FORM**

Contract No. 84168

<input type="checkbox"/> New Retiree Enrolment or <input type="checkbox"/> Change: (check boxes) →	<input type="checkbox"/> Change Coverage <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address for CSI (remember to report new address to Manulife on claim forms)	<input type="checkbox"/> Add Dependant <input type="checkbox"/> Change Co-ordination of Benefits	<input type="checkbox"/> Delete Dependant <input type="checkbox"/> Change Beneficiary	<input type="checkbox"/> Change Student Status
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SIN # \_\_\_\_\_ or Member ID# \_\_\_\_\_  
(if authorized) (assigned by CSI)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Full Address \_\_\_\_\_  
(street) (city) (province) (postal code)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Retirement Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male   
Day Month Year Day Month Year Female

Former School Name \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

**RETIREE PLAN** Includes Health, Dental and Life insurance. *Select one.*

- Single Coverage
- Family Coverage
- I choose not to participate in the CSI Retiree Insurance Plan.

**DEPENDANT COVERAGE** (for Family coverage only) Spouse and Dependent Children Information

Add Dependant(s)  Delete Dependant(s) Effective Date \_\_\_\_\_ Reason \_\_\_\_\_

	First Name	Last Name (if different)	Date of Birth dd/mm/yyyy	Gender M F	Full-time Univ. Student	Disabled Child
Spouse	_____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>		
Child	_____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child	_____	_____	____/____/____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CO-ORDINATION OF BENEFITS INFORMATION:** *Important information for paying claims.*

My spouse has coverage under his/her employer's plan: Health (choose one)  Single  Family  None  
Dental (choose one)  Single  Family  None

If this is a change in co-ordination of benefits, please list the effective date of the change \_\_\_\_\_

My child(ren) attending college or university full-time have coverage under a student plan: Child's Name \_\_\_\_\_  Health  Dental

If this is a change in co-ordination of benefits, please list the effective date of the change \_\_\_\_\_

If your dependent children have coverage under a former spouse's plan, please attach a separate note with details about their coverage.

**BENEFICIARY** *Must be completed by all former employees.*

Beneficiary designation is for Death Benefits ONLY. You may change the beneficiary at any time without the beneficiary's consent.

If your beneficiary is a minor, please contact CSI.

**Applicant's Beneficiary**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_

**AUTHORIZATION** *Must be completed to process.*

I am authorized to disclose information about my spouse and dependants in order to enrol them in the Plan. By enrolling in this Plan, I authorize Manulife Financial, its agents and service providers to collect, use, disclose and exchange information collected in this form to underwrite, administer and pay claims. I also authorize the Plan Sponsor, Christian Schools International (CSI) and its agents and service providers and my employer to collect, use, disclose, and exchange the information collected in this form to manage, administer, and arrange for benefits for me and my spouse and/or dependants, as applicable and to make any necessary payroll deductions which may be required. I authorize the use of my Social Insurance Number for administrative purposes. If my participation in this Plan and/or employment with a member school should end for any reason, this authorization will continue for the purposes of managing, administering, and arranging for benefits that my continue after my participation and/or employment terminates. I declare that the information above is accurate and true. Inaccurate information may invalidate my claim and/or participation in the Plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_