Over-Age Dependent Eligibility Declaration

Employee: To be completed in FULL for the eligible dependent child who is between 21 and 25 years of age and is registered full-time at a university or other post secondary institution as defined in the reference guide

EMPLOYEE INFORMATION (Please print clearly and initial any errors/changes)

Company Name:	Member ID:	Group Number:

Last Name:	First Name:	Gender: ☐ Male ☐ Female	Date of Birth: (dd/mm/yyyy)

Street Address:	Unit #:	PO Box:

City:	Province:	Postal Code:

Telephone:	Email:

DEPENDENT STUDENT INFORMATION #1

Last Name:	First Name:	Gender: ☐ Male ☐ Female	Date of Birth: (dd/mm/yyyy)

Name of Post Secondary School:	Student ID Number:	Expected date to graduate: dd/mm/yyyy
Street Address:	Unit #:	PO Box:
City:	Province:	Postal Code:
Program Enrolled:	Enrolled from: dd/mm/yyyy	Enrolled to dd/mm/yyyy

Status: ☐ Full-Time Student ☐ Co-operative Program Student ☐ Part-Time Student ☐ Distant Learning Course ☐ Correspondence Course

DEPENDENT STUDENT INFORMATION #2

Last Name:	First Name:	Gender: ☐ Male ☐ Female	Date of Birth: (dd/mm/yyyy)

Name of Post Secondary School:	Student ID Number:	Expected date to graduate: dd/mm/yyyy
Street Address:	Unit #:	PO Box:
City:	Province:	Postal Code:
Program Enrolled:	Enrolled from: dd/mm/yyyy	Enrolled to dd/mm/yyyy

Status: ☐ Full-Time Student ☐ Co-operative Program Student ☐ Part-Time Student ☐ Distant Learning Course ☐ Correspondence Course

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

All the information I have provided on this form is accurate and complete, to the best of my knowledge and understand that no benefits will be payable until the insurer approves this application. I authorize Benecaid to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. **Proof of student status may be required at time of claim, investigation or audit**. I acknowledge that more specific information about collection and use of my personal information can be found in the Policy section of www.benecaid.com. A photocopy or an electronic copy of this authorization shall be as valid as the original.

EMPLOYEE CERTIFICATION

Signature:	Date :(dd/mm/yyyy)

INFORMATION

This form is not required should the student have a letter from the registrar office stating full-time for the current term/year or an invoice showing full-time status with the current term/year paid in full. Confirmation of dependent child enrollment in a recognized educational institution must be submitted each semester/year until the student reaches the age of twenty-five or when the student graduates which ever comes first. Dependent eligibility terminates when; 1) reaches max age of a dependent, 2) ends enrollment at an accredited school, 3) plan member eligibility terminates. Benecaid must be notified immediately when eligibility has terminated.

Please submit your completed application to:

Benecaid Health Benefit Solutions Inc. 185 The West Mall, Suite 800, Toronto, Ontario M9C 5L5
Email: customercare@benecaid.com or Fax: 1-877-797-7449