



APPLICATION FOR COVERAGE OF DEPENDENT CHILD OVER AGE 21

(Please Print)

Policy Number: _____ Division Number: _____

Policyholder Name: _____

Plan Member's Name: _____

Certificate Number: _____

Child's Name: _____ Date of Birth: _____

Please check the applicable box, provide the necessary information, and sign below. If you have any questions regarding the completion of this form or coverage, please contact your Group Plan Administrator.

FULL-TIME STUDENT

A child who is in full-time attendance at an accredited post-secondary educational institution (College or University) may continue coverage if they are under the Maximum Age for Dependent Children in the Schedule of Benefits. They must continue to meet the definition of an eligible dependent according to the Group Policy. Some conditions include that they be unmarried, reside with the plan member, and not be engaged in any work for pay on a full-time basis. Coverage for students attending school outside of their home province will be restricted.

Coverage will terminate at the earlier of withdrawal from classes or when the student reaches the maximum age for an Overage Dependent under the terms of the Group Policy. Coverage for continuing students will be without disruption during breaks between terms.

Name of College or University: _____

Is the College or University within Canada? Yes No

Expected Completion Date of Schooling: _____

DISABLED CHILD

An unmarried child who was insured prior to age 21 as an eligible dependent of an insured employee may remain an eligible dependent if they were, prior to age 21, and continue to be, both incapable of self-sustaining employment by reason of a developmental or physical disability, and are chiefly dependent upon the insured employee for support and maintenance. Coverage must be applied for prior to the child's 21st birthday.

Satisfactory proof in the form of a letter from the child's attending physician that the conditions specified above exist must be attached to this application.

I certify that the named child meets the above applicable conditions.

Plan Member's Signature: _____

Date: _____