Application for Over-Age Dependent Child Benefits Coverage

Client Name _____ Group # _____

Employee Name _____ Certificate#/PIN_____

Dependent Information

First Name _____Initial _____ Last Name _____

Date of Birth _____

Please answer the following questions in respect to the above dependent:

He/She is:

1. A Full-Time student in a recognized school or college? ☐ Yes ☐ No (if Yes, please complete the following:

   Location/Province of College/University _____

   Provide the last year he/she will be in school _____

2. Working more than 30 hours/week on a regular year-round basis ☐ Yes ☐ No

3. DISABLED ☐ Yes ☐ No *If Yes, please contact GroupSource for the applicable form.
(A child is considered disabled if he/she is incapable of sustaining employment due to mental or physical handicap and is financially dependent on you or your spouse and claimed by you and your spouse on your income tax)

4. Married or in a Common-Law relationship ☐ Yes ☐ No Date of marriage or co-habitation _____
yyyy / mm / dd

Coverage can be continued to the maximum student age if the dependent meets the terms of the contract.

Satisfactory evidence of full-time attendance at School or University may be required.

This form must be returned to your Employer as soon as possible in order to maintain benefits coverage. If not returned, this dependents benefits will terminate in accordance with the contract.

Employee Signature

I hereby apply for benefits coverage for my over-age dependent.

Employee Signature _____ Date _____