OVER-AGE DEPENDANT FORM

Request for Student Coverage

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (Last Name, First Name)				DATE OF BIRTH (mm/dd/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | DEPENDANT INFORMATION

DEPENDANT NAME (Last Name, First Name)				DEPENDANT BIRTHDATE (mm/dd/yyyy)	
FULL TIME STUDENT (Y/N)		SCHOOL/COLLEGE/ UNIVERSITY			
START DATE OF COURSES (mm/dd/yyyy)		DATE OF EXPECTED GRADUATION (dd/mm/yyyy)			

DEPENDANT NAME (Last Name, First Name)				DEPENDANT BIRTHDATE (mm/dd/yyyy)	
FULL TIME STUDENT (Y/N)		SCHOOL/COLLEGE/ UNIVERSITY			
START DATE OF COURSES (mm/dd/yyyy)		DATE OF EXPECTED GRADUATION (mm/dd/yyyy)			

** **REQUIRED:** Please attach proof of enrolment to this form

PART 3 | PLAN MEMBER SIGNATURE

Whereas the "Company" refers to Canadian Benefit Providers Inc., I certify that the information in this form is true and complete to the best of my knowledge. I acknowledge and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. I authorize the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with my Plan Advisor, its reinsurers and/or its service providers, for the Purposes. I understand that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law.

PLAN MEMBER'S SIGNATURE	DATE (mm/dd/yyyy)

Forward this completed form by email, fax or mail to:
Email | admin@cbproviders.ca
Fax | 780.944.9168
Mail | Canadian Benefit Providers, #202, 10235-124th Street NW, Edmonton, Alberta, T5N 1P9, Canada

Questions?
Call us at 780.944.9166 ext 280, or toll free at 855.944.9166 ext 280
Email | helpdesk@cbproviders.ca

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