HealthSource Plus
Group Benefits · Administration · Wellness · Retirement

APPLICATION FOR OVER-AGE DEPENDENT COVERAGE

A: Employer Information

Employer's Name:

B: Member Information

Last Name	First Name	Policy Number	Certificate Number

C: Dependent Children

Dependent Child 1

Last Name	First Name	Date of Birth (DDMMYYYY)	Gender
			☐ Male ☐ Female

Name of Accredited School, College or University	The dependent child is enrolled as a full-time student From: (DDMMYYY) To: (DDMMYYYY) Anew form and proof of enrolment must be submitted by August 31st each year the dependent child is enrolled as a full-time student.

Dependent Child 2

Last Name	First Name	Date of Birth (DDMMYYY)	Gender
			☐ Male ☐ Female

Name of Accredited School, College or University	The dependent child is enrolled as a full-time student From: (DDMMYYY) To: (DDMMYYYY) Anew form and proof of enrolment must be submitted by August 31st each year the dependent child is enrolled as a full-time student.

D: Member Signature

Date	Signature of Member

PROOF OF ENROLMENT IS REQUIRED. PLEASE ATTACH A COPY FOR OUR RECORDS

Suitable proof includes a letter from the accredited school, college or university advising the child is a full time student or a copy of the paid tuition. A new form and proof must be submitted each school year.

Fax this completed form to your HealthSource Plus servicing office:

Toronto (416) 445.2222 **Montreal** (514) 331.6486

Niagara (905) 688.9368 **Winnipeg** (204) 940.3901