Student Benefits
Family Add-on Form & Receipt

A student benefits plan supplements coverage provided by basic medicare (providing coverage for things not covered by basic medicare, such as prescription drugs and dental). The coverage provided to the student can be extended to a spouse and/or dependent(s). To add eligible dependent(s) complete the sections below and return this form and the appropriate fee by the applicable deadline. Your family can only be covered while you are a student on the plan(s).

PLEASE NOTE: YOUR OPTIONAL FAMILY ADD-ON IS NOT AUTOMATICALLY RENEWED. IN ORDER FOR YOUR FAMILY ADD-ON TO CONTINUE, YOU MUST PURCHASE THE COVERAGE EACH BENEFIT YEAR BEFORE THE APPLICABLE DEADLINE. FAMILY ADD-ON FEES ARE NON-REFUNDABLE.

STUDENT INFORMATION

Last Name | First Name | Initial | Gender | Date of Birth (D D M M Y Y)

Mailing Address | City/Province | Postal Code

Campus of Study | Student ID Number

DEPENDENT INFORMATION

HEALTH — I wish to provide extended health coverage for my: ☐ Spouse ☐ Child ☐ Children

DENTAL — I wish to provide dental coverage for my: ☐ Spouse ☐ Child ☐ Children

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THOSE INDIVIDUALS WHO WILL BE COVERED AS SPOUSE OR DEPENDENT(S)

Spouse: Spouse means the person who is a resident of Canada, and who is married to the student, or a person of either sex who has continuously co-habitated with the student for a period of at least 12 months and who is publicly represented as the student's wife or husband.

Dependant(s): Dependant means an unmarried child who is a resident of Canada, and entirely dependent on the student for maintenance and support, and who is:

1) under 21 years of age,
2) under 25 years of age and attending a college or university full-time, or
3) physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on the student for maintenance and support and while eligible under 1) or 2) above.

Last Name | First Name | Initial | Gender | Date of Birth (D D M M Y Y)

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Last Name | First Name | Initial | Gender | Date of Birth (D D M M Y Y)

PAYMENT INFORMATION

Amount Paid | Payment Method

AUTHORIZATION

I understand that information provided above is required for me to provide the same dental and/or extended health benefits that I receive as a student to my spouse and/or dependent(s). I authorize the use of this information where it is required in the administration of these benefits. I am aware that this information will not be used in any manner other than to provide coverage through the student group benefits plan, and/or administration of this plan. I confirm that all information provided is accurate.

X | Student Signature | Phone ( ) - | Date (D D M M Y Y)

OFFICE USE ONLY | Processing Date (D D M M Y Y) | Processed By

GALLIVAN & ASSOCIATES STUDENT NETWORKS
The Integrated Care Solution