



500 – 2755 Lougheed Highway  
Port Coquitlam, BC V3B 5Y9

## Application for Over-Age Dependent Child

Name of Employer

▶ Use this form if you have a dependent child who has reached your plan's age limit, and is attending school full time or is handicapped. ◀

▶ This form is to be completed in BLUE INK. PLEASE PRINT. Please submit original form only — fax copies or photocopies cannot be accepted. ◀

### ▶ Employee – Complete for Over-Age Dependent Child Coverage ◀

Employee Last Name	First Name	Initial	Social Insurance/Certificate Number		
Dependent's Last Name	First Name	Initial	Month	Day	Year
▶ Please answer the following questions with respect to the dependent named above ◀					
1. Is he or she mainly dependent financially on you or your spouse? If "No" please explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. If he or she works or receives an income, indicate approximate annual earnings:			\$		
3. Is he or she residing with you or your spouse?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Is he or she married or living in a common law relationship?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Is he or she in full time attendance at a recognized School, College, or University? If "Yes" provide the following information: <small>(Satisfactory evidence of full time attendance at School, College, or University may be requested)</small>			<input type="checkbox"/> Yes <input type="checkbox"/> No		
● Name of School, College, or University:					
● Location:					
● Student Number:					
● Program of Study:					
● Duration of Program (In Full)		From:			To:
6. Is he or she handicapped? If "Yes" indicate the nature of the handicap and the date the handicap commenced.			<input type="checkbox"/> Yes <input type="checkbox"/> No		
I certify to the best of my knowledge the accuracy of the above information I have provided with respect to my over-age dependent child and agree to provide any further information that may be required by the insurers to verify the eligibility of such dependent.					
X _____			_____		
Signature of Employee			Date		