



Over Age Dependents

Western Canada

500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9
 Fax: 604.464.7997 Toll Free: 800.667.1336

Eastern Canada

107 - 6 Cataraqui Street, Kingston, ON K7K 1Z7
 Fax: 613.530.3770 Toll Free: 888.272.0414

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. ◀

► Employee – Complete for Over-Age Dependent Child Coverage ◀			
Employee Last Name	First Name	Initial	
Dependent's Last Name	First Name	Initial	Dependent's Date of Birth
			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