

To: Benefits Administrator/Human Resources Department
ID#:
From:
Date:
Re: Extended Health and Dental Coverage for Over Age Dependents

Our records indicate that you have one or more dependents enrolled in your extended health and/or dental plan. To qualify for enrolment as a dependent after reaching the age of 21 up until age 25, your child(ren) must meet the following criteria:

- Single (i.e. unmarried and not living in a common-law relationship) and financially dependent on the employee or spouse
- A natural, adopted, foster, or step-child, if the child is dependent on you for financial support
- Full-time student of an accredited educational institution (minimum 10 hours per week)
- Functionally impaired child who was insured as a dependent shall remain insured beyond any limiting age for dependents

Please complete the information requested below and return to your Benefits Administrator/Human Resources Department by the last day of the month of your over age dependents birthdate. If this form is not returned your dependent(s) coverage will be terminated as of the first of the following month.

<i>Name of Dependent(s)</i>	<i>Date of Birth</i>	<i>Age</i>	<i>Continue</i>	<i>Terminate</i>	<i>Date if terminating</i>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Full name and address of the school or university your son(s)/daughter(s) attends full time

Note: Only list your over age dependents who have an upcoming birthday. Memos will be sent at each over age dependent's birthdate. If you have any questions, or require assistance completing this form, do not hesitate to contact Benefits Administrator/Human Resources Department.

I certify that all information provided is correct. If any of my children are absent from their permanent province of residence, I certify that his/her absence is temporary and solely for attending an accredited educational institution.

Signature _____ Date _____

Return to: Benefits Administrator/Human Resource Department