Please send completed forms to:

Kechnie Benefits
262 Queen Street South
Kitchener ON N2G 1W3
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

OVER AGE DEPENDANT APPLICATION

EMPLOYEE NAME: _____

EMPLOYER NAME: _____

If your Dependant has reached the Plan's age limit and is not attending an accredited college or university on a full-time basis, he/she is no longer eligible for insurance coverage.

Dependant's Name: _____ Date of Birth: _____

To ensure that our records reflect accurate information, please complete the following:

1. Does the above named dependant attend college/university on a **full-time** basis?
_____ Yes _____ No

   Name and Location of College/University: _____

   Program of Study: _____

   Duration of Program: From _____ To _____

   Student Number: _____

Once you have received the documentation from the college/university confirming that your dependant is registered as a full-time student for the current/upcoming year (eg. Letter of acceptance, registration form, etc.), we ask that you please forward it directly to our office. Submitted claims may not be processed until this documentation has been received. Please note that it is a mandatory requirement that we receive this documentation each school year in order to continue coverage. If approved, coverage will continue until August 31st of the applicable school year.

2. Is the above named dependant employed? _____ Yes _____ No

   If Yes, how many hours per week does the dependant work? _____

I certify to the best of my knowledge that the above information that I have provided with respect to my over age dependant is true and agree to provide any further information that may be required by the insurer to verify the eligibility of such dependant.

_____ _____

Employee Signature **Date**

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Administrator Initials:_____