

OVER AGE DEPENDANT APPLICATION

****To ensure that our records reflect accurate information, please submit the following form at the beginning of each academic school year, 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.**

Employer :	Group No :
Employee name:	Certificate No :
Dependent's Name :	Date of Birth :

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 _____

Graduation Date: _____

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, unless the dependent graduates. Coverage terminates upon graduation.*

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: _____