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#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

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.	☐ Yes ☐ 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?	☐ Yes ☐ No
4. Is he or she married or living in a common law relationship?	☐ Yes ☐ No
5. Is he or she in full time attendance at a recognized School, College, or University? If "Yes" provide the following information: (Satisfactory evidence of full time attendance at School, College, or University may be requested)	☐ Yes ☐ 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.	☐ Yes ☐ 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

Last Updated April 21, 2004