Maximum benefit.

JG100

REQUEST FOR OVER-AGE DEPENDENT COVERAGE

◯ Claim Pending

Use this form to apply for group benefit coverage for over-age dependent children who are in full-time attendance at an accredited institute of learning. The child must not be married and not employed on a full-time basis or otherwise eligible for insurance as an employee under a benefit plan.

Please refer to your benefit booklet for the range of ages eligible for over-age benefits. (Note: EACH school year, a new Request for Over-age Dependent Coverage form must be completed and sent to Maximum Benefit at the address below.)

Firm/Company Name _____ Firm/Division # _____

Employee's Name _____ Certificate # _____

Dependent's Name _____ Dependent's Date of Birth ____/____/____ (YYYY / MM / DD)

1) Is the dependent married? ◯ No ◯ Yes

2) Is the dependent working full time? ◯ No ◯ Yes

If Yes, is the dependent eligible for benefits with their employer? ◯ No ◯ Yes

3) Is the dependent in full-time attendance at an accredited school? ◯ No ◯ Yes

If Yes, what is the name and address of the school? _____

_____

Program Enrolled _____ School Year 20____ to 20____

Expected date of graduation _____

If the student plans to return to school on a full time basis after this date, please indicate:

a) Program Enrolled _____ b) Date _____

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Maximum Benefit and its insurers to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. I authorize such collection and disclosure to be conducted by any means necessary, including electronic communication methods such as email. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

Any copy of this authorization shall be as valid as the original.

Signature of Employee _____ Date _____

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