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 full-time students. The over-age dependent must be in full-time attendance at an accredited institute of learning. The child must be unmarried and reside with the employee. (Your plan booklet defines the range of ages eligible for over-age benefits.) Send the completed form 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 over-age dependent wholly dependent upon you? ◯ No ◯ Yes

2) Is the dependent working full or part time? ◯ No ◯ Yes If Yes, # of hours per week ______

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? ______________________

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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.

A photocopy of this authorization is as valid as the original.

Signature of Employee ______________________ Date ______________________

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