



## APPLICATION FOR OVER-AGE DEPENDENCY CARD

COMPLETE THIS FORM TO APPLY FOR COVERAGE FOR ANY OVER-AGE DEPENDENT (ANY CHILD WHO HAS REACHED THE DEPENDENCY STATUS AGE LISTED ON THE MASTER APPLICATION) WHO STILL REMAINS A LEGAL DEPENDENT (IE: IS IN ATTENDANCE AS A FULL-TIME STUDENT AT AN ACCREDITED COLLEGE OR UNIVERSITY). COVERAGE UNDER THE OVER-AGE DEPENDENCY CARD TERMINATES ON AUGUST 31ST OF EACH YEAR, THEREFORE, THE SUBSCRIBER MUST RE-APPLY IF THE CHILD RE-ENROLS THE FOLLOWING SCHOOL YEAR.

TO RECEIVE A DEPENDENCY CARD, A CHEQUE PAYABLE TO CLAIMSECURE INC., IN THE AMOUNT OF \$5.00 PER CARD, MUST ACCOMPANY THIS APPLICATION.

### SUBSCRIBER INFORMATION

SURNAME (LAST NAME)	GIVEN (FIRST) NAME	MIDDLE INITIAL	POLICY / GROUP NUMBER	CERTIFICATE NUMBER
ADDRESS				
STREET	APT NO.	CITY	PROVINCE	POSTAL CODE
NAME OF EMPLOYER				

LIST ONLY THOSE OVER-AGE DEPENDENTS WHO STILL REMAIN YOUR LEGAL DEPENDENTS (i.e. ARE IN ATTENDANCE AS A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL/COLLEGE/UNIVERSITY) AND PROVIDE THE REQUESTED INFORMATION BELOW FOR EACH ELIGIBLE OVER-AGE DEPENDENT.

### DEPENDENT CHILD #1

SURNAME (LAST NAME)	GIVEN (FIRST) NAME	MIDDLE INITIAL	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (DAY/MONTH/YEAR)
NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY			THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM _____ TO _____ DAY/MONTH/YEAR                      DAY/MONTH/YEAR	

### DEPENDENT CHILD #2

SURNAME (LAST NAME)	GIVEN (FIRST) NAME	MIDDLE INITIAL	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (DAY/MONTH/YEAR)
NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY			THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM _____ TO _____ DAY/MONTH/YEAR                      DAY/MONTH/YEAR	

### DEPENDENT CHILD #3

SURNAME (LAST NAME)	GIVEN (FIRST) NAME	MIDDLE INITIAL	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (DAY/MONTH/YEAR)
NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY			THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM _____ TO _____ DAY/MONTH/YEAR                      DAY/MONTH/YEAR	

\*REMINDER TO ENCLOSE \$5.00 (INCLUDES G.S.T.) PER ELIGIBLE DEPENDENT TO COVER HANDLING COST OF ISSUING THE DEPENDENCY CARD.

UPON TERMINATION OF COVERAGE THE SUBSCRIBER MUST RETURN THE DEPENDENCY CARD(S) TO HIS/HER EMPLOYER.

NOTE: AN ELIGIBLE DEPENDENT'S DRUG COVERAGE AUTOMATICALLY TERMINATES UNDER ANY ONE OF THE FOLLOWING CONDITIONS:

1. REACHES THE MAXIMUM DEPENDENCY AGE OF THE CONTRACT.
2. MARRIES.
3. CEASES TO BE ENROLLED AT AN ACCREDITED SCHOOL/COLLEGE/UNIVERSITY AS A FULL TIME STUDENT. OR
4. THE SUBSCRIBER'S COVERAGE THROUGH CLAIMSECURE INC. TERMINATES.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND CONFIRM THAT I AM AUTHORIZED TO ACT ON BEHALF OF MY SPOUSE AND DEPENDENTS WHEN APPLYING FOR COVERAGE OR FOR PURPOSES OF THE ONGOING ADMINISTRATION OF MY HEALTH BENEFIT PLAN. I ALSO AUTHORIZE CLAIMSECURE, HEALTHCARE PROVIDERS, INSURERS, ADMINISTRATORS OF GOVERNMENT OR OTHER BENEFIT PLANS AND OTHER SERVICE PROVIDERS WORKING WITH CLAIMSECURE TO EXCHANGE ALL REQUIRED INFORMATION, INCLUDING THE INFORMATION ON THIS APPLICATION NECESSARY TO ADMINISTER MY HEALTH BENEFIT PLAN.

DATE

SIGNATURE OF SUBSCRIBER

\*RETURN APPLICATION AND MONEY FOR A SPECIAL OVER-AGE DEPENDENCY CARD TO YOUR PERSONNEL OFFICE.

Send form and inquiries to:

ClaimSecure Inc.  
43 Elm Street, Suite 200 Sudbury, Ontario P3C 1S4 • 1-888-513-4464