HealthSource Plus
Group Benefits · Administration · Wellness · Retirement

# APPLICATION FOR OVER-AGE DEPENDENT COVERAGE

## Member Information

| Last Name | First Name | Policy Number | Certificate number |
|---|---|---|---|
| | | | |

## Dependent Child #1

| Last Name | First Name | Date of Birth |
|---|---|---|
| | | |

| **Name of Accredited School/ College/ University** | **Male** ☐ **Female** ☐ | |
|---|---|---|
| | **The dependent child will/ is enrolled as a fulltime student*** **From** _____ **dd/mm/yy** **To** _____ | |

## Dependent Child #2

| Last Name | First Name | Date of Birth |
|---|---|---|
| | | |

| **Name of Accredited School/ College/ University** | **Male** ☐ **Female** ☐ | |
|---|---|---|
| | **The dependent child will/ is enrolled as a fulltime student*** **From** _____ **dd/mm/yy** **To** _____ | |

_____ **x**_____
Date Signature of Member

***Proof of Enrollment is required. Please attach a copy for our records.***
*(Suitable proof includes a letter from the University advising the child is a full time student or a copy of the paid tuition).*

**Once completed, fax to your HealthSource Plus servicing office:**

**Customer Service Centre Fax Numbers:**

Toronto (416) 445.2222 Montreal (514) 331.6486 Niagara (905) 688.9368