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