Health Benefits Adminstration
Seventh-day Adventist Church in Canada
1148 King Street East, Oshawa, ON L1H 1H8
Telephone: 1-800-263-7868 or 905-433-3964 • **Fax:** 905-433-3717

Over-Age Dependent Enrolment Form

An over-age dependent is defined as any child who has reached age 19 and remains a legal dependent. **(i.e. is in attendance as a full-time undergraduate student at an accredited college or university).**

This form must be completed if your child will be **turning 19 before August 31, 2020** or if your child has already reached the age of 19. **Coverage will terminate on your child's 19th birthday unless this form is completed and returned to** healthbenefits@adventist.ca**, or mailed into our office.**

The plan member must re-apply each year by August 31st for their overage dependent(s) to continue coverage. Please make any corrections directly on this form.

Plan Member Information

Employer Name			
Member Last Name	**First Name**		
Street Address	**City**	**Province**	**Postal Code**

Dependents Information

1.

Dependent Last Name	Dependent First Name	* Eligible for Coverage
		☐ Yes / ☐ No
Current Status (child or Student)	**Date of Birth (dd/mm/yyyy)**	**Sex (M or F)**

Name of Accredited School/College/University	Length of Program	Expected Graduation Date ☺

2.

Dependent Last Name	Dependent First Name	* Eligible for Coverage
		☐ Yes / ☐ No
Current Status (child or Student)	**Date of Birth (dd/mm/yyyy)**	**Sex (M or F)**

Name of Accredited School/College/University	Length of Program	Expected Graduation Date ☺

3.

Dependent Last Name	Dependent First Name	* Eligible for Coverage
		☐ Yes / ☐ No
Current Status (child or Student)	**Date of Birth (dd/mm/yyyy)**	**Sex (M or F)**

Name of Accredited School/College/University	Length of Program	Expected Graduation Date ☺

*** Eligibility:** An eligible dependent's coverage terminates under any of the following conditions:

1. Reaches the age of 24 (25 for Quebec)
2. Marries
3. Ceases to be enrolled at an accredited school/college/university as a full time undergraduate student (Coverage ceases the month of graduation or date of leaving school)
4. The plan member's coverage 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 Health Benefits Administration, healthcare providers, insurers, administrators of government, other benefit plans and other service providers working with Health Benefits Administration to exchange all required information, including the information on this application necessary to administer my health benefits plan.

Signature of Plan Member	Date Signed (dd/mm/yyyy)