Health Benefits Administration
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

Please complete this form and send to Health Benefits Administration by email to healthbenefits@adventist.ca or return by mail in the enclosed self-addressed envelope.

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 student at an accredited college or university, is under age 24 and has not completed their undergraduate degree).** Coverage for over-age dependents terminates on August 31st of each year **until they complete their undergraduate degree or age 24, whichever occurs first.** The plan member must re-apply each year the student is enrolled.

Plan Member Information

Company Name/Employer Name			
Member Last Name	**First Name**		**Middle Initial**
Street Address	**City**	**Province**	**Postal Code**

Dependent Information

Name of Accredited School/College/University		
Dependent Last Name	**Dependent First Name**	
Relationship to Plan Member	**Date of Birth (dd/mm/yyyy**	**Sex (M or F)**
School Year Start Date	**Length of Program**	**Expected Graduation Date ☺**

Dependent Information

Name of Accredited School/College/University		
Dependent Last Name	**Dependent First Name**	
Relationship to Plan Member	**Date of Birth (dd/mm/yyyy**	**Sex (M or F)**
School Year Start Date	**Length of Program**	**Expected Graduation Date☺**

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

1. Reaches the maximum student age of the Contract
2. Marries
3. Ceases to be enrolled at an accredited school/college/university as a full time undergraduate student or
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.

Plan Member Signature

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