

An over-age dependent is defined as any child who has reached the dependency status age listed on the Master Application and still remains a legal dependent (i.e. Is in attendance as a full-time student at an accredited college or university). Coverage for over-age dependents terminates on August 31st of each year, therefore, the plan member must re-apply if the child re-enrolls the following school year.

Plan Member Information

| | | | |
|-----------------------|------|--------------------|-------------|
| Employer/Company Name | | | |
| Group Number | | Certificate Number | |
| Last Name | | First Name | |
| Street Address | City | Province | Postal Code |

List information for **only** those OverAge Dependents who require coverage while attending an accredited school/college or university.

OverAge Dependent Information (OAD)

| | | | |
|---|--|---|--|
| Dependent Last Name | | Dependent First Name | |
| Relationship to Plan Member | Date of birth (dd/mm/yy) | Gender Female <input type="checkbox"/> Male <input type="checkbox"/> | |
| School Start date | School End Date August 31 / _____ (current year) | | |
| Name of accredited school/college/university (Optional) | | | |

| | | | |
|---|--|---|--|
| Dependent Last Name | | Dependent First Name | |
| Relationship to Plan Member | Date of birth (dd/mm/yy) | Gender Female <input type="checkbox"/> Male <input type="checkbox"/> | |
| School Start date | School End Date August 31 / _____ (current year) | | |
| Name of accredited school/college/university (Optional) | | | |

Note: Coverage for OAD terminates on August 31st of each year therefore, the member must re-apply if the child re-enrolls the next school year.

Authorization

Upon termination of coverage the plan member must return the dependency card(s) to his/her employer.

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 student or
4. The plan member'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.

| | | |
|---|------------|---|
| Plan Member Authorization | | |
| Signature of Plan Member | Print Name | Date signed (dd/mm/yy) |
| | | |
| Plan Sponsor Authorization | | |
| Signature of Plan Administrator | Print Name | Date signed (dd/mm/yy) |
| | | |
| <p>Please complete form and send to: E-mail: eligibilityupdates@claimsecure.com Or mail: CLAIMSECURE INC. PO BOX 6500 STN A SUDBURY ON P3A 5N5</p> | | |
| | | <p>Fax: 1-705-673-5968 Phone: 1-888-513-4464</p> |