Rainy River District Social Services Administration Board

Request for Over-Age Dependent Coverage

(Complete sections 1, 2 (if applicable), 3 and 5)

1. General Information	Employee Name	Plan Number	Plan Member ID	
	Last Name of Dependent	First Name of Dependent	Relationship to Plan Member	
	Dependent's Date of Birth (dd/mm/yy)	Dependent's Age	Sex ❑ Male ❑ Female	
	Address of Dependent	City	Province	Postal Code
2. Disabled Dependent Information If you are completing this section of the form, **please attach a report or letter from the dependent's personal physician** confirming the diagnosis and prognosis for the dependent, and the extent to which the physician determines the dependent is unable to work.	Is the disabled dependent a resident of your home 365 days a year? ❑ Yes ❑ No If "No", please explain.			
	Has the disabled dependent ever been employed? ❑ Yes ❑ No			
	If "yes", please give most recent date of employment and description of type of employment.			
	Date (mm/dd/yy)	Type of Employment		
	Is disabled dependent eligible for: a) Benefits under a government plan? b) Health, Dental, Disability Benefits from another group plan?	❑ Yes ❑ No ❑ Yes ❑ No		
	If answering "yes" to either of the above questions, please give complete details.			
	Are you the sole means of the disabled dependent's support? ❑ Yes ❑ No			
	If "No", please explain.			
3. Full-time Student	**Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up a August 31st of the next school year, the upper limit of the dependent definition age, or until coverage is terminated.**			
	Name of Accredited School/College/University	Location of School/College/University		
	Date School Year:	Begins (mm/dd/yy)	Ends (mm/dd/yy)	
4. Termination of Over-age Student Coverage This only applies if you have over-age dependent children who are no longer students	❑ I wish to terminate ALL coverage for	Dependent Name	Termination Date	
	Reason for Termination			
5. Plan Member Signature	I certify that the information in this form is true and complete, to the best of my knowledge. I authorize any health care provider, other insurance company, any type of worker's compensation board, my plan sponsor, or other persons to release and exchange information requested by Human Resources when the information is needed to process this application.			
Please Sign Here	Signature of Plan Member	Date Signed (mm/dd/yy)		

FOR OFFICE USE ONLY	
❑ Input into Sun Life system ❑ Original document filed	
Human Resources Officer:	Date Completed: