# University of Toronto
# Enrolment Form for Continuation of Green Shield Coverage for Over-Age Dependant(s) in Full-time Studies

## Introduction:

Under our Green Shield health plans dependants can include the natural, legally adopted, step or foster child of the employee/spouse who is unmarried, not engaged in active employment and dependant on the employee or spouse for financial support, and who is less than 21 years of age. Coverage as an over-age dependant can be continued up to age 25 if continuously enrolled and in full-time attendance at an accredited educational institution that provides a recognized certificate of accreditation on completion.

To confirm the dependant (s) eligibility for continuing coverage as an over-age dependant, the employee must complete and sign this form at the beginning of each school year. Please return completed forms to the Benefits Administration Office at: 215 Huron Street, 8th floor, Toronto, ON M5S 1A2 or by fax to (416) 978-5702 by October 16, 2006. If you have questions regarding coverage for over-age dependants, please contact benefits.help@utoronto.ca or call (416) 978-2113.

All coverage for over-age dependants ceases the end of the month in which they reach age 25 or October 31st immediately following the end of their full-time attendance at an accredited educational institution; whichever occurs first. Within 60 days of termination of coverage under our group plans, dependants may enrol in individual coverage through the Green Shield Conversion Plan. For more information call (416) 601-0429 in the Toronto area or toll-free at 1-800-667-0429 or visit www.4benefits.ca.

## Employee Information:

Last Name: _____ First Name: _____

Green Shield ID Number: UOT _____ Birthdate Y Y Y Y M M D D

Employment Status: Active ❑ Retired ❑ Surviving Spouse/Partner ❑

Mailing Address:
Street: _____

City _____ Province _____ Postal Code _____

E-Mail Address: _____ Day Time Telephone# _____

## Over-Age Dependant(s)Information

**1)** Family Name _____ First name: _____
(If Different than subscriber)

Birthdate Y Y Y Y M M D D Gender: M F

Name of Institution: _____ Attendance From: _____ To: _____
(E.g. Sept 1, 2006 to Aug 31, 2007)

**2)** Family Name _____ First name: _____
(If Different than subscriber)

Birthdate Y Y Y Y M M D D Gender: M F

Name of Institution: _____ Attendance From: _____ To: _____
(E.g. Sept 1, 2006 to Aug 31, 2007)

I hereby apply for Overage Dependant Coverage from Green Shield Canada for the above listed Dependant(s). I confirm that the above named Overage Dependant(s) is/are eligible for continued coverage under my Green Shield Family plans for the current academic year. I acknowledge all information is complete and accurate. I authorise my employer/policyholder, Green Shield Canada, and their respective representatives to give, receive and share any personal information regarding the eligibility and insurability of my Overage Dependant(s) under this plan.

Signature of Employee _____ Date Completed _____

**For Office Use Only:**

Reviewed By: _____ Date: _____

October 2006