

Over age dependant application



Complete and submit this form to Sirius Benefits by email, fax, or posted mail.

| | | | | | |
|---------------------------------|--|--------------------------|--|-------------------|--|
| Dependent name: | | Last | | First | |
| Dependent date of birth: | | DD/MM/YYYY | | | |
| Group plan no: | | Firm no: | | Firm name: | |
| Certificate no: | | Plan member name: | | | |

Is the over age dependent employed? Yes No

If yes, how many hours per week? _____

Is the over age dependent attending college or university? Yes No

If yes, please provide the following information:

Name and location of college or university _____

Program of study _____

Duration of program From _____ To _____

Student number _____

If the over age dependent is **not** attending college or university, is the over age dependent suffering from a severe, incurable, and chronic physical or mental disability which has resulted in you being fully responsible for their financial, mental and/or physical well-being? Yes No

If yes, please provide a letter from your medical doctor detailing the disability. Include details of onset, full diagnosis, prognosis, and information regarding the amount of care required.

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|--|--|--------------------|--|
| I certify that all of the information presented is true and accurate. I authorize Sirius Benefits and any other insurance company to exchange information when necessary to determine eligibility and to administer the plan. I understand that I am responsible for providing any additional requested information or proof that may be deemed as required. | | | |
| Plan member signature | | Date signed | |