Assumption Life
Group Insurance

Reset

Application for Over aged Dependency Coverage

This form is to be completed at least once a year by an employee wishing to apply for an over-aged student dependent. The dependent must be a child who is an over-aged dependent as specified in the contract and who is in attendance as a full-time student at a recognized academic institution. A new form must be completed by August 31 of each year if the dependent child re-enrolls as a full-time student at a recognized academic institution.

List and provide the requested information below only for the over-aged dependents who are in attendance, as full-time students, at a recognized academic institution.

Employee s Information

_____ _____ _____ _____ _____
First Name | Last Name | Policy | Division | Certificate

_____ _____ _____ _____
Address | City | Province | Postal Code

Dependent Child #1

_____ _____ ___ / ___ / _____
First Name | Last Name | Date of birth (DD/MM/YYYY)

_____ This child will be/is enrolled as a full-time student from ___ /___ /_____ to ___ /___ /_____
Name of Recognized Academic Institution | DD / MM / YYYY | DD / MM / YYYY

Dependent Child #2

_____ _____ ___ / ___ / _____
First Name | Last Name | Date of birth (DD/MM/YYYY)

_____ This child will be/is enrolled as a full-time student from ___ /___ /_____ to ___ /___ /_____
Name of Recognized Academic Institution | DD / MM / YYYY | DD / MM / YYYY

Dependent Child #3

_____ _____ ___ / ___ / _____
First Name | Last Name | Date of birth (DD/MM/YYYY)

_____ This child will be/is enrolled as a full-time student from ___ /___ /_____ to ___ /___ /_____
Name of Recognized Academic Institution | DD / MM / YYYY | DD / MM / YYYY

Note: An eligible over-aged dependent's coverage automatically terminates under any one of the following conditions:

1- He/she reaches the maximum dependency age specified in the contract,
2- He/she marries,
3- He/she ceases to be enrolled at a recognized academic institution as a full-time student, or
4- The employee's coverage terminates for any reason.

I, the undersigned, hereby certify, to the best of my knowledge, to the accuracy of the above information regarding my dependent children. I understand that Assumption Life may at any time require that proof be provided by the recognized academic institution confirming full-time registration of the dependent child. In addition, I acknowledge and understand that I am responsible to report, in writing, within 7 days, any changes in my dependent children's status to the policyholder.

_____ _____
Employee's Signature | Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-888-869-9797 Fax 1-855-401-9068 E-mail: group@assumption.ca