❑ Claim Pending

Retiree Plans

Johnston group

JG11-JG

REQUEST FOR OVER-AGE DEPENDENT COVERAGE

Please indicate your Firm & Certificate #

Firm #	Certificate #

Use this form to apply for benefit coverage for dependent children who are over age 21 and full-time students. Send the completed form to the National Service Centre at the address below.

Covered Individual's Name _____

Dependent's Name _____ Birth Date (YYYY/MM/DD) _____

1. Is the over-age dependent wholly dependent upon you? ❑ Yes ❑ No
2. Is the dependent working full or part time? ❑ Yes ❑ No If Yes, # of hours per week _____
3. Is the dependent in full-time attendance at an accredited school? ❑ Yes ❑ No

   If Yes, what is the name, address and phone number of the school? _____

   _____

   Program Enrolled _____ School Year 20____ to 20____

   Number of hours this program considers full time _____

   Number of hours this student is enrolled in program _____

   Expected date of graduation _____

   If the student plans to return to school on a full time basis after this date, please indicate:

   a) Date _____ b) # of classes/day ____ c) # of hours/day ____

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge. I acknowledge that no benefits will be payable until the insurer approves this application. I authorize Group Medical Services (GMS), Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.johnstongroup.ca. A photocopy of this authorization is as valid as the original.

Covered Individual's Signature _____ Date _____

NATIONAL SERVICE CENTRE
1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1-800-893-7587

Underwritten by Group Medical Services (GMS)