MEDIC SOLUTIONS
Group insurance, evolved

DECLARATION OF ELIGIBILITY FOR A FULL-TIME STUDENT

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Reserved by Medic Solutions Medic Client No. Medic certificate No.

A dependent beyond the age limit is defined as any child who has reached the age when they are considered independent under the terms of application, but remains a legal dependent (i.e. a full-time student at an accredited college or university). Coverage for any dependents beyond the stated age limit terminates on August 31 of every year; therefore, the plan member must submit a new application if the child enrolls in the following school year.

Information regarding the plan member

Employer's name			
Policy Nº	Certificate Nº		
Last name	First name		
Address	City	Province	Postal code

Please provide information **only** regarding dependents who exceed the stated age limit and require coverage as full-time students in an accredited college or university.

Information regarding the dependent

Last name of the dependent	First name of the dependent
Relationship with the plan member	Date of birth **(mm/dd/yyyy)**
Fall semester (September 1st to december 31) ☐	**Winter semester (January 1st to August 31)** ☐
Name of the school/accredited college/university	

Last name of the dependent	First name of the dependent
Relationship with the plan member	Date of birth **(mm/dd/yyyy)**
Fall semester (September 1st to december 31) ☐	**Winter semester (January 1st to August 31)** ☐
Name of the school/accredited college/university	

Note: This declaration must be completed twice a year and accompanied by a class schedule or invoice from the educational institution. The statement provided for the winter term recognizes the dependent for the period from January 1 to August 31 and the one for the fall term recognizes the dependent from September 1 to December 31. Part time semester is not admissible.

I hereby certify that I will notify Medic Solutions if my dependent interrupts his/her full-time studies, changes educational institution, gets married or lives with a partner.

I declare that the information provided above is complete and accurate.

I consent that a photocopy, digital copy or any other format of this Declaration and Consent Form bears the same value as the original.

Please complete this form and return it to: participant@medicsolutions.ca

Signature of the plan member

Date (mm/dd/yyyy)

Reset form