

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.

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	