EMPLOYEE BENEFIT PROGRAM
OVER-AGE DEPENDENT VERIFICATION FORM

PROCESSING INSTRUCTIONS:

An extension of coverage can be granted for dependent children if they are in full-time attendance at an accredited school, college or university. Coverage for eligible students terminates when they no longer qualify for student status or they attain the **plan termination age**, whichever occurs first. **Please refer to your Employee Benefit Booklet for complete details regarding eligibility requirements**. **Annual verification of student status is required by August 31st each year.** If we do not receive verification of over-age student status, we will assume coverage is no longer required and terminate the dependent's health and dental benefits on August 31st.

Please complete this form, in ink, and send the **original** signed form to:
The MEARIE Group - 3700 Steeles Avenue West, Suite 1100, Vaughan, Ontario, L4L 8K8

GENERAL INFORMATION (Part A)

EMPLOYER NAME			DIVISION NUMBER	
EMPLOYEE NAME Last Name	First Name	Middle Name	**ID NUMBER**	**CLASS**

STUDENT STATUS DECLARATION (Part B)

Name of Dependent Child: ____
(First Name) (Middle Name) (Last Name)

Gender: ☐ Male ☐ Female **Date of Birth** (YY/MM/DD):______________________

Is your dependent attending school as a full-time student: ☐ **Yes** ☐ **No** ***(If no longer attending school full-time, please complete Part C)***

If yes, please provide the following information:

Name of School:____

Full Address: ____

Please indicate when schooling commences and is scheduled for completion:

COMMENCEMENT DATE:

Month	Day	Year

SCHEDULED COMPLETION DATE:

Month	Day	Year

I certify that the statements above are accurate, true and complete in all respects. In the event that any such statement is inaccurate, untrue or incomplete in any respect, I understand and agree that all insurance coverage is voidable by the insurer.

EMPLOYEE'S SIGNATURE:______________________________ **DATE:** ______________
Month/Day/Year

STUDENT STATUS DECLARATION (Part C)

Name of Dependent Child: ____
(First Name) (Middle Name) (Last Name)

Gender: ☐ Male ☐ Female **Date of Birth** (YY/MM/DD):______________________

Please remove the dependent listed above from my health and dental benefits as they are no longer attending school on a full-time basis

effective ______________________.
Month/Day/Year

EMPLOYEE'S SIGNATURE:______________________________ **DATE:** ______________
Month/Day/Year

At The MEARIE Group, we recognize and respect every individual's right to privacy. We use the personal information provided to determine your eligibility for coverage and administer the group benefit plan.