Flexit360

# Group Benefits

◯ **Request for Over-Age Student Dependant Coverage (Complete sections 1, 2 and 4)**

◯ **Termination of Over-Age Student Dependant Coverage (Complete sections 1, 3 and 4)**

Please complete form and mail to: TELUS Health c/o Flexit360 Benefits Help Desk, 27th Floor, 25 York St., Toronto, ON, M5J 2V5 or scan completed form and email to Helpdesk_Flexit360@telus.com

## 1 General information

| Plan sponsor name | Plan number(s) | Plan member ID |
|---|---|---|
| Teva | | |
| **Last name of plan member** | **First name** | **Middle initial** |
| | | |
| **Address of plan member** | **City** | **Province** / **Postal code** |
| | | |

| Last name of dependant | First name | Relationship to plan member | Dependant's date of birth (dd/mmm/yyyy) | Sex ◯ Male ◯ Female |
|---|---|---|---|---|
| | | | | |

| Address of dependant | City | Province | Postal code |
|---|---|---|---|
| | | | |

## 2 Full-time student

Children over an age as specified in your Benefit Booklet are eligible for coverage provided they are enrolled at an accredited school/college/university as a full-time student. Coverage will be extended up to August 31st of the next school year, the upper limit of the dependant definition age, or until coverage is terminated.

| Name of accredited school/college/university | Location of school/college/university |
|---|---|
| | |

| Date school year: | Begins (dd/mmm/yyyy) | Ends (dd/mmm/yyyy) |
|---|---|---|
| | | |

## 3 Termination of over-age student coverage

This only applies if you have over-age dependant children who are no longer students.

◯ I wish to terminate ALL coverage for DEPENDANT NAME

Effective date of termination (dd/mmm/yyyy)

Reason for termination

## 4 Plan member signature

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor. I understand that certain aspects of such Coverage may extend to my spouse and eligible dependents (collectively, "Dependents").

I certify that the information in this form is true and complete to be best of my knowledge. I understand that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependents, in the future is true and complete to the best of our knowledge.

I acknowledge and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. I authorize the carrier to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes").

I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with the carrier, its reinsurers and/or its service providers, for the Purposes. I am authorized by my Dependents to consent to this Authorization, on their behalf as if they are signing it themselves, and to disclose and receive their Information, for the Purposes. I authorize my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. I authorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. I agree a photocopy or electronic version of this authorization is valid.

I understand that any Information provided to or collected by TELUS Health in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to be limited to TELUS Health employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access; and persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why TELUS Health collects, uses, maintains, and discloses my personal information can be found in TELUS Health's Privacy Policy and Privacy Information Package, or from my Plan Sponsor.

**Please sign and date here.**

| Plan member's signature | Date signed (dd/mmm/yyyy) |
|---|---|
| | |

Ce document est aussi disponible en français sur demande