# OVER-AGE STUDENT DEPENDANT
## Declaration Form

This form is to be completed by the Policyholder, or in the case of group coverage, the Plan Member.
Please return the declaration to GMS at **2055 Albert Street PO Box 1949 Regina, SK S4P 0E3, or fax to 306.525.6360.**
Completed declarations can also be scanned and emailed to *info@gms.ca*.

| **A. Policyholder/Plan Member Information** | | |
|---|---|---|
| First Name | Last Name | GMS ID Number |

| **B. Over-Age Dependant Information** | | |
|---|---|---|
| First Name | Last Name | Date of Birth *(DD/MM/YYYY)* |
| Address *(if different from Policyholder/Plan Member)* | | |

**C. Over-Age Student Dependant Declaration (Complete this section if the over-age dependant is attending an educational institution)**

❑ I declare the dependant listed in Section B. is a full-time student as described in the definition of dependant in my booklet/policy.

*Dependants between the ages detailed in your booklet/policy are eligible for coverage if they are enrolled at an accredited educational institution, school, college or university as a full-time student. Coverage for eligible dependants will be extended until August 31st of the next school year, or up to the dependant's birthday when they reach the maximum age listed in your booklet/policy, or until coverage is terminated.*

| Name of Educational Institution Dependant is Attending Full-Time | Location of Educational Institution |
|---|---|
| Enrolment Start Date *(DD/MM/YYYY)* | Enrolment End Date *(DD/MM/YYYY)* |

I declare the statements made herein are true and complete. I also declare that I am the guardian, caregiver, and/or parent of the dependant. I hereby authorize physicians, health care providers, or other persons, hospitals or institutions to release to Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers (collectively "GMS") any information covering my dependant's medical history symptoms, treatment, examination, diagnosis and/or services rendered to my dependant.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to: (a) collect, store and use any personal information which I, or my dependant, have provided to GMS or personal information obtained pursuant to clause (b); and/or (b) obtain personal information about my dependant (or any other person listed herein) from, or disclose such personal information to: my dependant's Government Health Insurance Plan; the operator of any hospital, clinic , or other health facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required for the purposes described above.

I understand that any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the questionnaire may void my coverage and my dependant's coverage. I am authorized by my dependant(s) to consent to this Over-Age Student Dependant Declaration Form, on their behalf as if they were signing it themselves, and to disclose and receive their information, for the purposes of administering these benefits.

I acknowledge that more specific details regarding what GMS does with my personal information, and the personal information of my dependant(s), can be found in GMS' Privacy Policy at www.gms.ca/privacy-policy.

I acknowledge that I may be required to complete this form on an annual basis.

| Signature of Policyholder/Plan Member<br>**X** | Date *(DD/MM/YYYY)* |
|---|---|

**D. Removal of Over-Age Dependant from Plan (Complete this section if the over-age dependant is no longer attending an educational institution)**

❑ I declare the dependant listed in Section B. is NOT a full-time student as described in the definition of dependant in my booklet/policy.

Since the dependant is not a full-time student, I acknowledge that they cease to be covered under this plan as of the date this signed declaration is received by GMS.

I declare that the statements made herein are true and complete. I also declare that I am the guardian, caregiver, and/or parent of the dependant.

| Signature of Policyholder/Plan Member<br>**X** | Date *(DD/MM/YYYY)* |
|---|---|

I agree that my electronic signature in this agreement has the same legal effect as handwritten signatures. Electronic signatures include any information in electronic form that a party has created or adopted in order to sign a document and that is in, attached to, or associated with the document, including signatures sent by fax or email.