



APPLICATION FOR OVER-AGE DEPENDENCY CARD

THIS FORM IS TO BE COMPLETED AT LEAST ONCE A YEAR BY THE SUBSCRIBER WISHING TO APPLY FOR AN OVER-AGE DEPENDENCY CARD FOR ANY OF HIS/HER OVER-AGE DEPENDENTS (ANY CHILD HAVING REACHED THE AGE LISTED UNDER THE DEPENDENCY STATUS ON THE SUBSCRIBER'S I.D. CARD) WHO STILL REMAIN LEGAL DEPENDENTS (i.e. ARE IN ATTENDANCE AS A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL/COLLEGE/UNIVERSITY).

OVER-AGE DEPENDENCY CARDS WILL NOT BE ISSUED BEYOND AUGUST 31st OF ANY SCHOOL YEAR (i.e. THE EXPIRY DATE ON THE CARD WILL BE AUGUST 31st AND A SUBSCRIBER WILL HAVE TO RE-APPLY FOR A NEW DEPENDENCY CARD IF THE CHILD RE-ENROLS AS A FULL-TIME STUDENT THE FOLLOWING SCHOOL YEAR).

SUBSCRIBER INFORMATION

Form with fields: SURNAME (LAST NAME), GIVEN (FIRST) NAME, MIDDLE INITIAL, POLICY / GROUP NUMBER, CERTIFICATE NUMBER, ADDRESS (STREET, APT NO., CITY, PROVINCE, POSTAL CODE), NAME OF EMPLOYER

LIST ONLY THOSE OVER-AGE DEPENDENTS WHO STILL REMAIN YOUR LEGAL DEPENDENTS (i.e. ARE IN ATTENDANCE AS A FULL-TIME STUDENT AT AN ACCREDITED (SCHOOL/COLLEGE/UNIVERSITY) AND PROVIDE THE REQUESTED INFORMATION BELOW FOR EACH ELIGIBLE OVER-AGE DEPENDENT.

DEPENDENT CHILD #1

Form for Dependent Child #1 with fields: SURNAME (LAST NAME), GIVEN (FIRST) NAME, MIDDLE INITIAL, SEX, DATE OF BIRTH(DAY/MONTH/YEAR), NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY, THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM TO

DEPENDENT CHILD #2

Form for Dependent Child #2 with fields: SURNAME (LAST NAME), GIVEN (FIRST) NAME, MIDDLE INITIAL, SEX, DATE OF BIRTH(DAY/MONTH/YEAR), NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY, THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM TO

DEPENDENT CHILD #3

Form for Dependent Child #3 with fields: SURNAME (LAST NAME), GIVEN (FIRST) NAME, MIDDLE INITIAL, SEX, DATE OF BIRTH(DAY/MONTH/YEAR), NAME OF ACCREDITED SCHOOL/COLLEGE/UNIVERSITY, THE CHILD WILL BE/IS ENROLLED AS A FULL-TIME STUDENT FROM TO

UPON TERMINATION OF COVERAGE THE SUBSCRIBER MUST RETURN THE DEPENDENCY CARD (S) TO HIS/HER EMPLOYER.

- NOTE: AN ELIGIBLE DEPENDENT'S DRUG COVERAGE AUTOMATICALLY TERMINATES UNDER ANY ONE OF THE FOLLOWING CONDITIONS: 1. REACHES THE MAXIMUM DEPENDENCY AGE OF THE CONTRACT, 2. MARRIES, 3. CEASES TO BE ENROLLED AT AN ACCREDITED SCHOOL / COLLEGE / UNIVERSITY AS A FULL-TIME STUDENT. OR 4. THE SUBSCRIBER'S COVERAGE THROUGH CLAIMSECURE INC. TERMINATES.

I, THE UNDERSIGNED, HERBY CERTIFY TO THE BEST OF MY KNOWLEDGE THE ACCURACY OF THE ABOVE INFORMATION I HAVE PROVIDED REGARDING MY DEPENDENT CHILDREN. IN ADDITION, I UNDERSTAND THAT I AM RESPONSIBLE TO REPORT, IN WRITING, WITHIN SEVEN (7) DAYS, ANY CHANGES IN MY DEPENDENT CHILDREN'S STATUS TO THE POLICY HOLDER AND TO RETURN THE SPECIAL DEPENDENCY CARD(S) UPON TERMINATION OF COVERAGE (AS DEFINED ABOVE).

DATE

SIGNATURE OF SUBSCRIBER

Send form and inquiries to Assumption Life:

770 Main Street, PO Box 160, Moncton, New-Brunswick E1C 8L1 1-800-455-7337

