

DEPENDENT'S STATEMENT

FILL OUT THIS STATEMENT ONLY IF:

- . your insurance certificate specifies family, couple or single-parent coverage;
- . you are changing your individual coverage to family, couple or single-parent coverage;
- . you are adding a new eligible dependent.

Proof of registration in an educational institution is required to pay benefits for dependent children aged 18 to 25 inclusively or 21 to 25 inclusively (depending on the contract provisions), if all the required information is not provided.

IDENTIFICATION - Please print

Name of policyholder	Contract Number	Account Number
Name of participant		Identification Number

IDENTIFICATION OF DEPENDENTS (according to the contract)

SPOUSE		
Last name	First name	Date of birth Y M D
1. Date of marriage: Y M D OR: Date of beginning of cohabitation: Y M D		
2. Is your spouse insured under another group plan?		
a) health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, provide the following information: Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Single-parent Name of insurer: _____ Contract No.: _____ Effective date: Y M D	b) dental care insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, provide the following information: Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Single-parent Name of insurer: _____ Contract No.: _____ Effective date: Y M D	

DEPENDENT CHILDREN					
Last name	First name	Sex	Date of birth	Age 18 or 21 to 25 inclusively (depending on the contract)	
				Full-time student	Educational institution enrolled in
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No From Y M D To Y M D	
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No From Y M D To Y M D	
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D	<input type="checkbox"/> Yes <input type="checkbox"/> No From Y M D To Y M D	

DECLARATION

I declare that the information above is complete and accurate. I can provide, upon request, proof of eligibility of my dependent(s) (e.g. proof of marriage, cohabitation, birth, adoption, registration in an educational institution).

Signature of participant

Date