Declaration of Student Eligibility

Group Name _____ Group # _____ Division # _____

Insured Employee's Name _____ Certificate # _____

RWAM Insurance Administrators – Group Administrator _____ Date _____

If your dependent is age 21 or over and <u>not</u> attending an accredited college/university as a full-time student, he/she is not eligible for insurance coverage.

I declare that the following dependent is eligible/not eligible according to the following information:

1. Dependent's Name _____ Date of Birth _____
2. Does the above mentioned dependent attend college/university? ☐ No ☐ Yes - If 'Yes', please complete the following:
3. Relationship to insured _____
4. Name of School Attending _____

   Address _____ Phone # _____

   _____ Fax # _____

   _____
5. Student Status: ☐ Full-time ☐ Part-time
6. Student is enrolled in the semester starting ___/___/___ (dd mm yy) and ending ___/___/___ (dd mm yy)
7. Will student be graduating at the end of the semester indicated above? ☐ Yes ☐ No

Notes:

- Submitted dependent claims may not be processed until this declaration has been received by RWAM. If approved, coverage will continue until August 31 of the applicable school year, provided the dependent attended school for the Winter term.
- Declaration must be provided for each full school year the dependent attends school.
- If your dependent attends an accredited college/university on a full-time basis, coverage continues until his/her 25th birthday. You will not be notified of this termination of coverage.

DECLARATION and CONSENT:

I declare that the statements made on this form with regard to my dependent's status as a student are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided.

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc. (RWAM) and the insurer for the purposes of determining eligibility for my dependent's group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer's plan administrator, RWAM and the insurer to exchange any relevant and necessary information for such purposes. I confirm I am authorized to act on behalf of the above dependent for such purposes. This authorization will remain valid for as long as I am claiming dependent benefits or services, or revoked by myself.

Date _____ Employee Signature _____

Please return to your employer's authorized plan administrator or send directly to RWAM.

RWAM INSURANCE ADMINISTRATORS INC.

49 Industrial Dr. Elmira, Ontario N3B 3B1 ph. 1.877.888.7926 519.669.1632 fx. 519.669.1923 www.rwam.com