HEALTH ASSOCIATION NOVA SCOTIA

OVERAGE DEPENDENT FORM (STUDENT)

Employee's Name (PRINT): _____

Certificate #: _____

(Available on cover memo or Health/Dental Benefits Card)

To remain qualified as a dependent after reaching the age of 21 up until the dependent's 26 birthday, your child must meet **ALL** the following criteria:

- ✓ **is under age 26 and a full-time student at an accredited school, college, or university; and**
- ✓ **is unmarried (legally or common law); and**
- ✓ **is not employed on a full-time basis; and**
- ✓ **is not eligible for benefits as an employee under this or any other group plan.**

If you have a child who is incapable of employment due to a mental or physical condition that occurred before reaching the maximum age noted above, coverage will continue if approved by the insurance company. For Health and/or Dental you must complete the Manulife Application for Overage Disabled Dependent (Form #55), and for Life Insurance you must complete the Sun Life Financial Disabled Child (Form #68). Forms are available at www.healthassociation.ns.ca/benefits/forms.

If your dependent child meets all the above dependent criteria please complete and sign this form. Please return the completed form, to your Benefits Administrator (or as directed) as soon as possible. Overage coverage for eligible dependents (students) runs from October 1 of one year to September 30 of the following year.

Name of Dependent	
Date of Birth (MM/DD/YYYY)	
Name of accredited school, college or university	
	School Term _____ to _____ (MM/DD/YYYY) (MM/DD/YYYY)

Declaration and Authorization.

I certify all information provided is correct. If my dependent child is absent from their permanent province of residence, I certify his/her absence is temporary and solely for attending an accredited educational institution. In signing this form I declare my dependent meets all the above criteria. At this time, Health Association Nova Scotia does not ask for proof of current attendance at an accredited school, however, we retain the right to request proof. If you have made a false declaration it may result in repayment of benefits claimed.

Signature_____ **Date**_____
(MM/DD/YYYY)

If you have questions or require assistance, please contact your Benefits Administrator or Group Benefits Solutions at 1 (866) 886-7246.

Employer Section – To Be Completed By the Authorized Benefits Administrator

Benefits Administrator Name (Please Print) _____**Division**_____
Signature_____ **Date**_____
(MM/DD/YYYY)

Employers, please forward original to Health Association Nova Scotia, Group Benefits Solutions, 2 Dartmouth Rd, Bedford, NS B4A 2K7