OVERAGE DEPENDENT FORM (STUDENT)

Employee's Name (PRINT): ____

Employee #: ____

(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; and**
- ✓ **a stepchild of a common-law spouse must be living with the employee.**

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, please contact HANS for more information.

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.

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**__________________________

PLEASE RETURN THIS FORM TO THE BENEFITS ADMINISTRATOR AT YOUR EMPLOYER.

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) ________________________________ **NSHA Central Zone**

Signature________________________________ **Date**__________________________

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