Declaration of Student Eligibility

GROUP INFORMATION

Group Name		Group #		Div. #	
Insured Employee Name		Certificate #			

If your dependent is age 21 (or according to your plan design) or over and not attending an accredited college/university as a full-time student, he/she is not eligible for insurance coverage.

STUDENT STATEMENT

Dependent eligibility will be determined based on the information provided below.

Dependent Name/Student		Date of Birth	
Does the above-mentioned dependent attend college/university?	☐ Yes ☐ No If 'Yes', complete Student Statement section		
Relationship to Insured			
Name of School Attending			
School Address (include Country)			
School Phone		School Email	

If studying out of province of residence, please complete: OUT-OF-PROVINCE/CANADA COVERAGE EXTENSION REQUEST FOR STUDENT STUDY/WORK TERM

Student Status	☐ Full-time ☐ Part-time		
Student is enrolled for the school year starting		and ending	
Will student be graduating at the end of the year indicated above?	☐ Yes ☐ No		

Please Note:

- Submitted dependent claims may not be processed until this declaration has been received by RWAM. If approved, coverage will continue until August 31st of the applicable school year (December 31st, if only attending fall term).
- A declaration must be provided for each full school year the dependent attends.
- If your dependent attends an accredited college/university on a full-time basis, coverage continues until their 25th birthday (or according to your plan design). A termination notice will not be sent.
- RWAM must be notified if the student withdraws for any reason from full-time studies.
- If your dependent is insured prior to age 21 (or according to your plan design) and unable to attend college or university, and incapable of self-sustaining employment due to being permanently disabled, please contact RWAM to apply for coverage extension. Coverage must be applied for prior to the child's 21st birthday (or according to your plan design).

AUTHORIZATION/DECLARATION/CONSENT

I understand that RWAM Insurance Administrators Inc. (RWAM) and the insurer will use the information provided on this form to determine my dependent's eligibility for group insurance coverage and benefits, and to administer such coverage/benefits. I confirm I have authority to act for and permission to provide information, including any Personal Information, on behalf of my dependent for such purposes. I hereby authorize my employer's plan administrator, RWAM and the insurer to exchange any relevant and necessary information for such purposes. I understand and agree that the use and exchange of any Personal Information provided on this form will be governed by RWAM's Privacy Policy located at www.rwam.com/privacy. This authorization will remain valid for as long as I am claiming dependent benefits or services unless I revoke it in writing. A copy of this document shall be as valid as the signed original.

By signing below, I agree to the above and I declare that all information provided on this form is complete, current, and true. I understand that any coverage granted may be voided if any information I provide is incomplete, outdated, or false.

_____ Employee Signature	Date

Please print and sign.

Return to your Employer's Authorized Plan Administrator or email directly to RWAM at: csr-groupadmin@rwam.com

Out-of-Province/Canada Coverage Extension Request for Student Study/Work Term

For students on a study/work term who expect their related travels to exceed the standard Maximum Trip Duration coverage under their Out-of-Province/Canada group plan

INSURED EMPLOYEE & STUDENT INFORMATION

Group Name		Group #		Div. #	
Insured Employee Name		Certificate #			
Dependent Name/Student					

TRAVEL & STUDY/WORK TERM DETAILS

Name of Host Academic Institution or Co-op Program		Is the Student Receiving a Sports Scholarship?	☐ Yes ☐ No
Address of Host Institution			

Scheduled DEPARTURE Date		Scheduled RETURN Date	
Scheduled START Date of Formal Study/Work Term		Scheduled COMPLETION Date of Formal Study/Work Term	

If the trip duration outside the Student's province of residence is scheduled to be more than 6 continuous months (7 months for Ontario), they must obtain an extension to their provincial health insurance coverage from the applicable Ministry of Health prior to departure. (Attach a copy of confirmation of such extension to this form.)

POTENTIAL TRAVEL DETAILS

Does the Dependent Student intend to travel to any destinations OTHER than the location of the Host Institution indicated above?	☐ Yes ☐ No If 'Yes', Detail Destinations			
Does the Dependent Student intend to return to their home province of residence at any time during their Study/Work term (e.g. during holiday seasons)?	☐ Yes ☐ No			
	If 'Yes', Province of Residence			
	From		To	

CONTACT INFORMATION

The decision on this Coverage Extension Request may be communicated by email to the contact person noted below.

Contact		Email	

Relationship: ☐ Plan Administrator ☐ Insured Employee ☐ Student ☐ Other _____

Any Coverage Extension granted will be limited to a maximum of 60 days combined between the Departure Date and the Return Date, before or after the Study/Work Term period. You must buy separate individual "top up" coverage for the period over 60 days. Call RWAM at 1-877-888-7926 email: OOC-groupclaims@rwam.com

AUTHORIZATION/DECLARATION/CONSENT

By signing below, the **Insured Employee and the Dependent Student** confirm we understand that RWAM Insurance Administrators Inc. (RWAM) and the Out-of-Province/Canada (OOC) insurer will use information, including Personal Information, provided on this form to determine eligibility for the above-requested coverage extension and to validate, administer and process any OOC benefit claim. With respect to any such claim, we authorize RWAM, the insurer and any applicable third parties to disclose and exchange any information, including Personal Information, required to administer, process or validate the eligibility and accuracy of such claim. We understand and agree that the use and exchange of any Personal Information provided on this form will be governed by RWAM's Privacy Policy located at www.rwam.com/privacy . We declare and confirm that the statements made on this form are complete, current and true and we understand that if any statement is incomplete or false, any coverage extension granted may be voided by either of RWAM or the insurer or such party as designated by them.

Also, the **Dependent Student** acknowledges and understands by signing below, that in the event of an OOC claim, it may be necessary to disclose and exchange relevant claims-related information, which may include Personal Information, with the Insured Employee and hereby authorizes and consents to such disclosure and exchange by RWAM, the insurer or the applicable third party. Claim-related information may include - but is not limited to - Personal Information about the Dependent Student, ongoing status of any claim, provider costs (which may or may not be eligible for payment of benefits under this coverage), and any decisions made with respect to any claim. This authorization will remain valid for as long as I am claiming dependent benefits or services unless I revoke it in writing. A copy of this document shall be as valid as the signed original.

_____ Insured Employee Signature	Date
_____ Dependent Student Signature	Date

RWAM USE ONLY

Extension Request: ☐ Granted ☐ Declined	on		Initials		Coverage Extension Period Granted From		to