



# 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 not attending an accredited college/university as a full-time student, he/she is not eligible for insurance coverage.***

## STUDENT STATEMENT

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 # \_\_\_\_\_

*\* If studying out of province of residence, please complete the reverse.*

5. Student Status:  Full-time  Part-time

6. Student is enrolled for the school year starting \_\_\_\_\_ and ending \_\_\_\_\_  
dd / mm / yy dd / mm / yy

7. Will student be graduating at the end of the year indicated above?  Yes\*  No  
*\* If 'Yes', coverage will terminate at the end of the graduating month or dependent maximum age, whichever is earliest.*

### Please Note:

- Submitted dependent claims may not be processed until this declaration has been received by RWAM. If approved, coverage will continue until August 31 (unless graduating) of the applicable school year.
- 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.

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