DECLARATION OF STUDENT ELIGIBILITY

Group Name _____ Group # _____ Division # _____

Insured Employee's Name _____ Certificate # _____

RWAM's 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.

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? O No O 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: O Full-time O Part-time
6. Student is enrolled for the school year starting ____/____/____ (dd mm yy) and ending ____/____/____ (dd mm yy)
7. Will student be graduating at the end of the year indicated above? O Yes* O 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.

O _____ _____

Employee Signature Date

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

49 Industrial Dr. Elmira, Ontario N3B 3B1 Phone 1-877-888-7926 519-669-1632 Fax 519-669-1923 www.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

RWAM Group #	Name of Group	Insured Employee's Certificate #

Name of Insured Employee	Name of Dependent Student

TRAVEL & STUDY/WORK TERM INFORMATION

Name of Host Academic Institution or Co-op Program

Location of Host Institution (Province and/or Country) where Study/Work term will take place

Student's scheduled **Departure Date**	Student's scheduled **Return Date ***
Year Month Day	Year Month Day
Scheduled START Date of formal Study / Work Term	Scheduled COMPLETION Date of formal Study / Work Term
Year Month Day	Year Month Day

***N.B.** If the Dependent Student's trip duration outside their province of residence is scheduled to be **longer than 6 continuous months (7 months for Ontario), it is necessary to obtain an extension to their provincial health insurance coverage from their Ministry of Health prior to departure**. *Attach a copy of confirmation of the provincial health coverage extension to this form.*

POTENTIAL TRAVEL

Does the Dependent Student intend to travel to any destinations OTHER than the location of the Host Institution indicated above? o No

o Yes, Destination(s) _____

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)?

o No o Yes, Province of residence _____ From _____ to _____
Year Month Day Year Month Day

CONTACT INFORMATION

The decision on this Coverage Extension Request may be communicated to the contact person indicated & their fax number or e-mail address provided below:

Name of Contact Person _____ Relationship o Plan Administrator o Insured Employee o Student

Via Fax to this fax # (_____) _____-_____ Via e-mail to _____

Note: If this group Coverage Extension Request is granted, it will be limited to a maximum total of 60 days' combined extension between the Departure Date and the Return Date, before and/or after the formal Study/Work Term period. Any extra coverage beyond this 60 day limit must be purchased under separate "top up" individual insurance. Call RWAM at 1-877-888-7926 Ext# 221.

Authorization:

I/we understand the information provided on this form will be used by RWAM Insurance Administrators Inc. (RWAM) and the insurer for the purposes of determining eligibility for the coverage extension requested and for any benefits claimed; and for validating, administering and processing any claim. I/we hereby authorize the exchange of relevant information relating to any claim incurred during the Study/Work Term and the granted Extension Period with RWAM and the insurer to and from other parties as may be necessary and required to administer, process and validate the eligibility and accuracy of any claim for Out-of-Province/Canada (OOC) benefits. I/we declare that the statements made on this form are complete and true. I/we understand that if any statement is incomplete or false, any Coverage Extension Period granted may be voided. A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

Signature of Insured Employee X_____ **Date** _____

Further to my authorization as agreed to above, in the event that I do incur claim(s), I acknowledge that as the dependent claimant under the Insured Employee's group OOC coverage, it may be necessary to exchange all relevant claims-related information with the Insured Employee; and I hereby authorize the exchange of all relevant claims-related information as necessary to the Insured Employee. For example, claims-related information may include but not be limited to the ongoing status of my claim(s), the provider(s)' costs which may or may not be eligible for payment of benefits under this OOC coverage, and the final decision(s) made on my claim(s).

Signature of Dependent Student ***X*** _____ **Date** _____

RWAM USE ONLY

Extension Request o Granted o Declined	Coverage Extension Period Granted
_____ on _____	From _____ to _____
Initials of RWAM Administrator Year Month Day	Year Month Day Year Month Day