Dependent Add-on Form

Policy #30394000

IMPORTANT – PLEASE READ THE FOLLOWING
In order to add dependent(s), please complete this form and submit it to your respective CCSAI office with payment on or before **Thursday, May 25, 2017** by 3:00 p.m. Please be prepared to provide your Centennial College student ID.

In cases where payment is not received, dependent coverage will not be applied.

Student coverage (including dependent(s) - if applicable) will terminate at the end of each semester in which the student is enrolled in or immediately upon withdrawal from enrolment status. Dependent coverage is on a semester basis and is not automatically renewed each subsequent semester.

STUDENT INFORMATION – PLEASE PRINT CLEARLY

Last Name	First Name	Student Number	Gender	Date of Birth (m/d/yr)

DEPENDENT INFORMATION – PLEASE PRINT CLEARLY

Please choose one of the following options:
*I wish to provide extended healthcare for my spouse or dependent child (for $45 per semester) ❑ Yes
*I wish to provide extended healthcare for my spouse and dependent child and/or dependent children (for $65 per semester) ❑ Yes

Last Name	First Name	Gender	Date of Birth (m/d/yr)	Relationship
Last Name	First Name	Gender	Date of Birth (m/d/yr)	Relationship
Last Name	First Name	Gender	Date of Birth (m/d/yr)	Relationship
Last Name	First Name	Gender	Date of Birth (m/d/yr)	Relationship
Last Name	First Name	Gender	Date of Birth (m/d/yr)	Relationship

AUTHORIZATION – PLEASE PRINT CLEARLY

I understand that the information provided above is required to provide the same extended health care benefits that I receive as a student to my spouse and/or dependent(s). I hereby authorize and consent to the use, release, and exchange of the above information between the Centennial College Student Association Inc. and Medavie Blue Cross to be used solely in connection with these benefits. I confirm that all the information provided by me herein is accurate. I also understand that if Medavie Blue Cross requires proof of relationship between my dependent(s) and myself, it is my responsibility to show proof of such. Failure to do so will result in termination of this plan without reimbursement.

***Your authorized signature confirms that you are a current full-time student of Centennial College who has paid the mandatory $17.50 health plan fee for the Summer 2017 semester.**

X	X	X	X
Student Signature	Phone number	Email Address (my.centennial)	Date of Signature (m/d/yr)

C C S A I O F F I C E U S E O N L Y

Policy #30394000
Summer 2017

Payment Information ❑ **$45** ❑ **$65** ❑ **Cash** ❑ **Debit** ❑ **Visa** ❑ **MasterCard**

Campus	Payment Processed By – CCSAI Personnel	Date of Payment	Invoice #

Dependent Add-on Form
Revised August 23, 2016