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