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	