

Over Age Dependent – School Form

Employee LAST & FIRST Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employer/Company Name	Policy/Group #:
	Employee/Cert #:


Address	City	Province	Postal Code
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**It is the responsibility of the member to advise of any change in student status.
If your dependent child is working 30 hours/week or more, he/she does not qualify for coverage.**

Last & First Name		Date of Birth (mm/dd/yy)	Relationship	Attending School?
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Post Secondary School:	Program:	Hours/week	Start (mm/dd/yy)	Finish (mm/dd/yy)
Last & First Name		Date of Birth (mm/dd/yy)	Relationship	Attending School?
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Post Secondary School:	Program:	Hours/week	Start (mm/dd/yy)	Finish (mm/dd/yy)

Protecting your personal information: At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Name of Employee (Please Print)	Signature of Employee	Date
Plan Administrator (Please Print)	Signature of Plan Administrator	Date

 <p>ProBenefits Inc. employer benefit solutions</p>	<p>Submit to: #8 4402 37 Street Stony Plain AB T7Z 2A9 Phone 780 963 5230 Fax 780 963 0982 Toll Free 800 375 3360 or e-mail to: claims@probenefitsinc.ca</p>
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