Over-age Dependent Verification Form (POLICE)

MEMBER INFORMATION			
Name:	**Badge #:**	**Status:** ☐ Active ☐ Retired	**Group:** ☐ Sworn ☐ Civilian

SECTION 1: ELIGIBILITY REQUIREMENTS

Complete this form only if your dependent is, or will be, turning 22 within the school year.

Your Green Shield group benefit contract defines a dependent as:

- Your child (your or your spouse's natural, legally adopted or stepchildren), that resides with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed.
- Unmarried child, 22 years of age and over, enrolled and in full-time attendance at an accredited college, university or educational institute.

Your Desjardins group benefit contract defines a dependent as:

- Is under 22 years of age, and for whom the participant or the spouse of the participant has legal guardianship or had legal guardianship until they reached the age of majority.
- Has no spouse, is 27 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the participant or the spouse of the participant would have legal guardianship if they were a minor.

Other Important Information:

- To maintain your dependent's coverage beyond age 22, this form must be completed and submitted **before their 22nd birthday**. Failure to do so will result in coverage ending at age 22.
- If your child is age 22 or older and attending school full-time, **complete this form before the start of each school year** to maintain uninterrupted coverage. A school year is considered September 1 – August 31.
- Your dependent's life insurance coverage ends at age 27, regardless of full-time student status.

Please submit the completed form to Human Resources at HR@police.sarnia.on.ca

SECTION 2: DEPENDENT INFORMATION

Name	Age	School Year *(yyyy - yyyy)*	School

SECTION 3: AUTHORIZATION

I certify that, as the plan member, I am applying for coverage for the over-age dependent(s) listed above and that the information provided is true and complete. I understand that I must notify Human Resources if eligibility requirements are no longer met. Failure to complete this form will result in termination of coverage for my over-age dependent(s).

_____

Employee Name (print)

_____ _____

Employee Signature Date