NORTHERN EMPLOYEE BENEFITS SERVICES
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5122 53rd Street, Yellowknife NT, X1A 1V6
Ph: (867) 873-4965 Fax: (867) 873-5801

DECLARATION OF STUDENT ELIGIBILITY
GROUP INSURANCE

COMPLETE THIS FORM FOR EACH ELIGIBLE DEPENDENT CHILD OVER THE AGE OF TWENTY-ONE (21) AND UNDER THE AGE OF TWENTY-FIVE (25). THEY MAY BE ELIGIBLE FOR CONTINUED COVERAGE UNDER THE NEBS GROUP INSURANCE PLANS. TO BE ELIGIBLE, THE EMPLOYEE'S CHILD MUST BE IN FULL-TIME ATTENDANCE AT AN ACCREDITED UNIVERSITY OR SIMILAR INSTITUTION, NOT BE WORKING ON A FULL-TIME BASIS AND BE FINANCIALLY DEPENDENT ON THE MEMBER. TO REMAIN ELIGIBLE THE MEMBER MUST COMPLETE THE FOLLOWING DECLARATION EACH YEAR.

PLEASE PRINT CLEARLY IN BLUE INK AND RETURN ORIGINAL SIGNED FORM TO THE NEBS OFFICE.

MEMBER INFORMATION

Effective date of Change: _____

Group Number: 799 Account Number: _____ Certificate Number: _____

Employee Name: _____

Employer Name: _____

DEPENDENT INFORMATION

Dependent Name: _____ Date of Birth: _____ (DD / MM / YYYY)

Name of University, College, or School: _____

Program Enrolled: _____

Length of Program: _____

Student Status (Full Time, etc.): _____

Student is enrolled for the school year starting _____ (DD / MM / YYYY) and ending _____ (DD / MM / YYYY)

Will student be graduating at the end of the school year indicated above? (Yes or No) * _____

* IF YES, COVERAGE WILL TERMINATE AT THE END OF CLASSES OR DEPENDENT MAXIMUM AGE, WHICHEVER IS LESS

NOTE: VERIFICATION OF STUDENT STATUS MUST BE SUBMITTED BEFORE JUNE 30th OF EACH YEAR OF ENROLMENT. ANY CLAIMS MADE AFTER THAT WILL BE HELD PENDING STUDENT ELIGIBILITY FORM.

AUTHORIZATION

NORTHERN EMPLOYEE BENEFITS SERVICES PRIVACY STATEMENT: Northern Employee Benefits Services (NEBS) is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I declare that the information contained herein is true, complete, accurate, and understand that the submission of false or incomplete information may result in denial of coverage or the delay and/or denial of any claim. I hereby authorize the Employer, NEBS, the insurance underwriters and the above-named educational institution to release and exchange with NEBS, the insurance underwriters or their representative or agents' any and all information or records necessary to determine my dependent's student enrollment status. I understand that such information may be necessary to determine my dependent's eligibility for coverage, adjudicate claims and administer the benefit plan. I confirm that I am authorized to act on behalf of my dependent for such purposes. Any copy of this authorization shall be valid as the original.

_____ _____

Employee Signature Date