OVERAGE DEPENDENT APPLICATION

Group #:		**Firm #:**		**Firm Name:**	
Certificate #:			**Member Name:**		

Dependent Name	Last	First
Dependent Date of Birth	DD/MM/YYYY	

Is this overage dependent employed? ☐ yes ☐ no

If yes, how many hours per week? ____________________

Is this overage dependent attending college or university? ☐ yes ☐ no

If yes, please provide the following information:

Name and Location of College or University ____________________

Program of Study ____________________

Duration of Program From __________ To __________

Student Number ____________________

If this overage dependent Is **not** attending college or university, is the overage dependent suffering from a severe, incurable and chronic physical or mental disability which has resulted in you being fully responsible for the overage dependent's financial, mental and/or physical well-being? ☐ yes ☐ no

If yes, please provide a letter from your medical doctor detailing the disability. Include details of onset, full diagnosis, prognosis and information regarding the amount of care required for your child.

I certify that all of the information presented is true and accurate. I authorize Sirius Benefit Plans and any insurance companies to exchange information when necessary to determine eligibility and to administer the plan. I understand that I am responsible for providing any additional requested information or proof that may be deemed as required.

Member Signature		**Date Signed**	