DEPENDENT CHILDREN OVER Age 21 FORM

OASIS
BENEFIT PLANS FOR NOT-FOR-PROFITS

Agency Information	Agency Name:		Agency ID#/ Location Number:		
Employee Information	Last Name:	First Name:		Certificate ID Number:	
OASSIS Policy	This form must be received by OASSIS within 31 days from the date the dependent attains the limiting age under your group benefit plan. If written notice is received after 31 days from the date the dependent attains the limiting age, benefits coverage will be terminated and/or subject to proof of good health with the carriers and any applicable plan restrictions/limitations to reinstate coverage.				
Definition – Dependent Children Over Age 21	Your unmarried child between the age 21-25, if enrolled and in full-time attendance at an accredited college, university or educational institute that is recognized by the Income Tax Act (Canada).* Proof of student status is required on an annual basis. Your child (your or your spouse's natural, legally adopted or stepchildren) must reside with you in a parent-child relationship or be dependent upon you (or both) and not regularly employed. Children who are in full-time attendance at an accredited school do not have to reside with you or attend school in your province. If the school is in another province, you must apply to your provincial health insurance plan for an extension of coverage to ensure your child continues to be covered under a provincial health insurance plan.				
Dependent Information	**Last Name**	**First Name**	**Date of Birth** (YYYY-MM-DD)	**Name of School**	**Date School Year Begins** (YYYY-MM-DD)	**Date School Year Ends** (YYYY-MM-DD)
	☐ My dependent(s) _____ are no longer attending full-time studies at a school. Please remove my dependent from my coverage under the group benefit plan.					
Authorization Both the employee and the authorized agency signatures are required.	I declare that all the information above is accurate and true. In the event that my dependent no longer qualifies in the future, I will notify my employer and OASSIS immediately. I understand that making a false statement on this form or otherwise can result in the termination of my coverage (and that of my spouse and dependents) with OASSIS. Employee Signature: _____ Date: _____ Authorized Agency Signature: _____ Date: _____					

*The definition for a dependent child may differ depending on your OASSIS group plan. Refer to your OASSIS Health and Dental booklet for the definition.

Submit this form using one of the following methods: Mail/ Fax/ Email Your OASSIS Benefits Administrator

OASSIS 5403 Eglinton Ave. West, Suite 101 | Toronto, Ontario M9C 5K6
Phone: 416-781-2258 | Toll Free: 1-888-233-5580 | Fax: 647-689-3061