REQUEST FOR OVERAGE DEPENDENT COVERAGE

Use this form to request Extended Health Care coverage for over age dependent child(ren) who are full-time students.
Please send the completed form to the Health Care Providers Group Insurance Plan in order for your overage dependents to retain their coverage.

Plan Member's Name _____

Green Shield ID# _____

Dependent's Name _____

Dependent's Date of Birth _____/_____/_____
YY MM DD

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1) Is the over age dependent wholly dependent upon you? Yes _____ No _____

2) Is the dependent in full-time attendance at an accredited school? Yes _____ No _____

If so, what is the name, address and phone number of the school? _____

_____

Program Enrolled _____ from _____/_____/_____
YY MM DD

to _____/_____/_____
YY MM DD

Number of hours/courses this program considers full time _____

Number of hours this student is enrolled in program _____

Expected date of graduation _____

I certify that the above information is true and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____