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? _____________________

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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** _________________