

REQUEST FOR OVER AGE DEPENDANT STUDENT COVERAGE

Group name	Group number	Division
------------	--------------	----------

Employee certificate number	Dependant name	Date of birth (dd/mm/yy)	Name of school	Start date of course	Full time attendance?
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no
					<input type="radio"/> yes <input type="radio"/> no

Please enclose the completed form with your REGULAR premium payment, mail separately, fax to 1 888 841-9145 or email to group.csu@empire.ca.

Note: School coverage ends every August 31st. Please remember to notify us each year.

