



12 MONTH EXTENDED FORM (Graduating Students Only)

Extended Health & Dental Benefits

University of Toronto Graduate Students' Union

Graduating members of the Health and/or Dental Plans may extend their coverage for 12 consecutive months by applying at the GSU. If August 31, 2010 was the last day of your coverage, you must purchase an additional 12 months of health/dental coverage on or before October 8, 2010, or for coverage ending on December 31, 2010 on or before February 4, 2011. Sorry, we cannot accept applications after the dates specified above unless there are exceptional circumstances. You must return this form with a personal cheque or money order (cash not accepted) made payable to "Graduate Students' Union" by Friday, October 8, 2010 or if your coverage ended December 31, 2010 by Friday, February 4, 2011. Please return the completed application form and cheque/money order to:

Health and Dental Office, 16 Bancroft Avenue, Toronto, ON, M5S 1C1

Telephone: 416.978.8465 E-mail: health@utgsu.ca

For detailed plan information, visit: www.greenshield.ca/studentcentre

STUDENT INFORMATION: Please print all information clearly and ensure that your information is correct.

_____	_____	_____	_____	MM DD YY
Last Name	First Name	Initial	Gender	Date of Birth
_____			_____	_____
Mailing Address			City/Province	Postal Code
_____			MM DD YY	_____
Academic Programme Name			Programme Start Date	Student ID Number

FAMILY INFORMATION: Please print all information clearly and ensure that your information is correct.

_____	_____	_____	_____	MM DD YY
Last Name	First Name	Initial	Gender	Date of Birth
_____	_____	_____	_____	MM DD YY
Last Name	First Name	Initial	Gender	Date of Birth
_____	_____	_____	_____	MM DD YY
Last Name	First Name	Initial	Gender	Date of Birth

BY COMPLETING THIS APPLICATION FORM YOU AGREE TO THE FOLLOWING:

I understand that information provided above is required for me to receive the 12 Month Extended Health and Dental benefits for myself and/or my spouse and/or dependent children. I authorize the use of this information where it is required in the administration of benefits. I am aware that this information will not be used in any manner except to provide coverage through the student group benefits plans, and/or administration of this plan. I confirm that all information provided above is accurate.

X	()	_____	MM DD YY
Student Signature	Telephone	Email	Date

Extended HEALTH Coverage	Single \$315.10	Couple \$629.64	Family of 3 or more \$821.71
Extended DENTAL Coverage	Single \$198.72	Couple \$392.99	Family of 3 or more \$517.66

I would like to purchase extended coverage:

For the following plans:	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Dental Plan
For the following period:	<input type="checkbox"/> Sept 1, 2010 to Aug 31, 2011	<input type="checkbox"/> Jan 1, 2011 to Dec 31, 2011

_____	_____	MM DD YY
Processed By:	Health Only/Dental Only (BOTH)	Date