



# 12 MONTH EXTENDED FORM (Graduating Students Only)

## Extended Health & Dental Benefits

University of Toronto Graduate Students' Union  
Benefit Period: January 1, 2010- December 31, 2010

The University of Toronto Graduate Students' Union benefits plans are supplemental coverage to basic medicare, providing coverage for medical expenses not covered by provincial medicare, such as prescription drugs and dental care. The benefits provided to graduating students can be extended to a spouse and/or dependent children. Please see the back of this form for 12 month extended coverage benefit rates and important deadlines. ONLY THE STUDENT HEALTH PLAN ADMINISTRATOR CAN PROCESS YOUR FAMILY APPLICATION FORM. To add eligible dependents, complete the sections below and return this form and the appropriate fee. Student starting in January must return completed forms between Monday, January 4 and Friday, February 5, 2010. Please return completed forms 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](http://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
_____	_____	_____	_____	MM   DD   YY
Last Name	First Name	Initial	Gender	Date of Birth

BY COMPLETING THIS FAMILY APPLICATION FORM YOU AGREE TO THE FOLLOWING:

I understand that information provided above is required for me to provide the same extended health and dental benefits that I receive as a graduating student to my spouse and/or dependent children. I further understand that the Accidental Death and Dismemberment benefits offered by ACE INA are for members only and are NOT available to my spouse and/or dependents. I authorise 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

<b>FOR OFFICE USE ONLY</b>	_____	_____	12 or 6 mos
	_____	_____	Health Premium Collected
_____	MM   DD   YY	_____	12 or 6 mos
Processed By:	Date Processed	_____	Dental Premium Collected

