



# OPT-IN FORM

## Extended Health & Dental Benefits

**University of Toronto Graduate Students' Union**  
**Benefit Period: September 1, 2010 - August 31, 2011**

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 graduate students can be extended to a spouse and/or dependent children. To add eligible dependents, complete the sections below and return this form and the appropriate fee. Students starting in September must return completed form between August 31st to October 8th, 2010. Students starting in January must return completed form between January 3<sup>rd</sup> to February 4<sup>th</sup>, 2011. Please return completed form 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	

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 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

X ( ) MM DD YY

<b>Student Signature</b>	<b>Telephone</b>	<b>Email</b>	<b>Date</b>
	<b>Students Starting in September 2010</b>		<b>Students starting in January 2011</b>
<b>Health Plan</b>	Couple \$216.22      Family (3+) \$344.26	Couple \$144.15      Family (3+) \$229.51	
<b>Dental Plan</b>	Couple \$133.66      Family (3+) \$216.73	Couple \$89.11      Family (3+) \$144.49	

**I would like to purchase:**

For the following plans:  Health Plan  Dental Plan  
 For the following period:  Sept 1, 2010 to Aug 31, 2011  Jan 1, 2011 to Aug 31, 2011

MM DD YY

Processed By: \_\_\_\_\_ Health Only/Dental Only (BOTH) \_\_\_\_\_ Date \_\_\_\_\_