



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, 2011 was the last day of your coverage, you must purchase an additional 12 months of health/dental coverage on or before October 7, 2011, or for coverage ending on December 31, 2011 on or before February 3, 2012. No exceptions will be made. You must return this form with a personal cheque or money order (cash not accepted) made payable to "Graduate Students' Union" by the deadlines. 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.

_____	_____	_____	DD MM YY
Last Name	First Name	Gender	Date of Birth
_____	_____	_____	
Mailing Address		City/Province	Postal Code
_____	<input type="checkbox"/> Fulltime <input type="checkbox"/> Part time	DD MM YY	
Academic Programme Name		Programme End Date	Student ID Number

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

_____	_____	_____	DD MM YY
Last Name	First Name	Gender	Date of Birth
_____	_____	_____	DD MM YY
Last Name	First Name	Gender	Date of Birth
_____	_____	_____	DD MM YY
Last Name	First Name	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 plans, and/or administration of this plan. I confirm that all information provided above is accurate.

X () _____ | DD | MM | YY |

Student Signature Telephone Email Date

Extended HEALTH Coverage Single \$314.57 Couple \$627.82 Family of 3 or more \$819.10
Extended DENTAL Coverage Single \$218.28 Couple \$431.99 Family of 3 or more \$569.24

I would like to purchase extended coverage:

**For the following plans:
For the following period:**

Health Plan **Dental Plan**
Sep **2011 to Aug 31, 2012** Jan **2012 to Dec 31, 2012**