



**May be faxed to 204.488.6008 or
emailed to info@siriusbenefits.ca**

OVERAGE DEPENDENT APPLICATION

Group #:		Firm #:		Firm Name:	
Certificate #:		Member Name:			

Dependent Name:	Last	First
Dependent Date of Birth:	DD/MM/YYYY	

Is this overage dependent employed? yes no
 If yes, how many hours per week? _____

Is this overage dependent attending college or university? yes no
 If yes, please provide the following information:

Name and Location of College or University _____
 Program of Study _____
 Duration of Program From _____ To _____
 Student Number _____

If this overage dependent **is not** attending college or university, is the overage dependent suffering from a severe, incurable and chronic physical or mental disability which has resulted in you being fully responsible for the overage dependent's financial, mental and/or physical well-being? yes no
 If yes, please provide a letter from your medical doctor detailing the disability. Include details of onset, full diagnosis, prognosis and information regarding the amount of care required for your child.

I certify that all of the information presented is true and accurate. I authorize Sirius Benefit Plans and any insurance companies to exchange information when necessary to determine eligibility and to administer the plan. I understand that I am responsible for providing any additional requested information or proof that may be deemed as required.			
Member Signature		Date Signed	
		DD/MM/YYYY	