

Group Benefits Student Eligibility Form

Employee

Employer:		Certificate:
Last name:	First name:	

Dependant

Last name:	First name:	Birth date: (yyyy/mm/dd)	
School name:			
School address:			
Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Correspondence <input type="checkbox"/> Co-op	Start date: (yyyy/mm/dd)	End date: (yyyy/mm/dd)	Graduating: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Note: If student not graduating on end date, another "Student Eligibility" form will be required to continue benefits.

Declaration

I declare that the information provided here is true, complete and accurate. A copy of this authorization shall be considered as valid as the original.

Employee signature:

Dated: (yyyy/mm/dd)

Employer signature:

Dated: (yyyy/mm/dd)