DECLARATION OF STUDENT ELIGIBILITY

Group Name | Group # | Division #

Insured Employee's Name | Certificate #

RWAM Insurance Administrators
– Group Administrator | Date

If your dependent is age 21 or over and <u>not</u> attending an accredited college/university as a full-time student, he/she is not eligible for insurance coverage.

STUDENT STATEMENT

I declare that the following dependent is eligible/not eligible according to the following information:

1. Dependent's Name　　Date of Birth
2. Does the above mentioned dependent attend college/university?　No　Yes - If 'Yes', please complete the following:
3. Relationship to insured
4. Name of School Attending

   Address*　　Phone #

   Fax #

   ** If studying out of province of residence, please complete the reverse.*
5. Student Status:　Full-time　Part-time
6. Student is enrolled for the school year starting ______ dd mm yy　and ending ______ dd mm yy
7. Will student be graduating at the end of the year indicated above?　Yes*　No

   ** If 'Yes', coverage will terminate at the end of the year or dependent maximum age, whichever is earliest.*

Please Note:

- Submitted dependent claims may not be processed until this declaration has been received by RWAM. If approved, coverage will continue until August 31 (unless graduating) of the applicable school year.
- Declaration must be provided for each full school year the dependent attends school.
- If your dependent attends an accredited college/university on a full-time basis, coverage continues until his/her 25th birthday. You will not be notified of this termination of coverage.

Declaration and Consent:

I declare that the statements made on this form with regard to my dependent's status as a student are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided.

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc. (RWAM) and the insurer for the purposes of determining eligibility for my dependent's group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer's plan administrator, RWAM and the insurer to exchange any relevant and necessary information for such purposes. I confirm I am authorized to act on behalf of the above dependent for such purposes. This authorization will remain valid for as long as I am claiming dependent benefits or services, or revoked by myself.

______________________　　______________________
Date　　Employee Signature

Please return to your employer's authorized plan administrator or send directly to RWAM.

RWAM INSURANCE ADMINISTRATORS INC.

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