STUDENTS STUDYING/WORK TERM ABROAD
INSURANCE EXTENSION REQUEST

(Duration exceeding Group Insurance Out-of-Province/Canada Plan)

PLEASE PRINT

STUDENT STATEMENT

RWAM Group #	Name of Policyholder/Group	Certificate #
Name of Employee	Name of Dependent Student	
Date of Departure	Date of Return	

COURSE / WORK INFORMATION

Name of Host Academic Institution or Co-op Program	
City and Country of Host Institution	
Study / Work Term Start Date	Study / Work Term Completion Date

POTENTIAL TRAVEL

Does the dependent student intend to travel to other countries? ❑ No ❑ Yes

If 'yes' please indicate which countries _____

_____

CONTACT INFORMATION

Please provide the appropriate contact information on who RWAM should respond to (via facsimile) regarding this request:

Name _____ ❑ Plan Administrator ❑ Parent ❑ Student

Fax # _____

Please Note:

If insurance coverage extension is granted, it will be limited to 60 days of coverage after the completion date of the course of study or work term. Any time after the 60 day period will have to be "topped up" with alternative coverage that must be purchased prior to the departure date. Top-up coverage can be purchased through RWAM Insurance Administrators Inc. 1-877-888-7926 ext. 221.

Provincial coverage from the Ministry of Health must be extended for durations longer than 6 months (7 months for Ontario) prior to departure. Please attach confirmation of this coverage extension.

Authorization:

I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I declare that the statements made on this form are complete and true. I hereby authorize the release of any information in respect to any claim incurred during my study/work term, requested by RWAM Insurance Administrators Inc. ("RWAM"), to RWAM and to the insurer. I also authorize my plan administrator, to exchange information, which is necessary and related to any claim during my study/work term, on my behalf with RWAM and the insurer.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

_____ _____

Signature of Employee Date

_____ _____

Signature of Dependent Student Date

OFFICIAL USE ONLY

Extension Request Granted by	Extension Period Granted
_____ on _____	From _____ to _____
Name of RWAM Administrator yyyy/mm/dd	yyyy/mm/dd yyyy/mm/dd

This form must be completed in full. If not, the form will be returned to you which will delay the processing of the request.
Please remit form to:

RWAM INSURANCE ADMINSTRATORS INC.

49 Industrial Dr., Elmira, ON N3B 3B1 Tel. 877-888-7926 or 519-669-1632 Fax 519-669-1923