Opt-in and Add Dependants Form

Student Information

All information is mandatory:

First name: _____ Last name: _____

Student ID Number: _____ Date of Birth (YYYY/MM/DD): _____/____/____

Preferred email: _____ Phone Number: _____

For opt-in requests:

Opt-in to the Health Plan: ___Yes ___No Opt-in to the Dental Plan: ___Yes ___No

Add Dependants (optional)

If you choose to add your eligible spouse and/or dependant children to the KSU Plan, you must complete the required form each year, **online at studentbenefits.ca**.

Dependant's benefits will become active after the payment is received by the Administrator. You will be charged one time only, to add your dependant(s) regardless of the number of dependants.

Dependant's Last Name	**Dependant's First Name**	**Relationship to Member**	**Date of Birth** (YYYY/MM/DD)	**Opting in to:**
				Health: ___ Yes ____No Dental: ___ Yes ____No
				Health: ___ Yes ____No Dental: ___ Yes ____No
				Health: ___ Yes ____No Dental: ___ Yes ____No
				Health: ___ Yes ____No Dental: ___ Yes ____No

When adding dependants or opting in to the plan, the additional fee must be sent to the Services and Campaigns coordinator by e-transfer to **fvp@ksu.ca,** before your requested coverage will be activated. Please include your Student B00# in the subject line and also specify in the e-transfer message whether you are opting in to the Health plan, Dental plan, or both. To see the Fee Chart, please visit **https://ksu.ca/health-dental/**

Authorization

On Behalf Of Myself and My Dependants (if applicable):

- I hereby confirm that the information contained in this form is true and complete to the best of my knowledge.
- I understand that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.
- I acknowledge my request to opt-in and/or add my family to my Health and/or Dental Plan for the duration of my current eligibility period is dependent upon my participation in the Plan(s). I acknowledge the add dependant request must be completed annually. I also acknowledge that should a dependant lose coverage from an alternate extended health and/or dental provider, I may only enroll the dependant in the current Health and/or Dental Plan by submitting a written request, accompanied by Alternate Plan termination documentation no later than 30 days following the loss of this existing coverage.

Signature: _____ Date: _____

Submit this form to the KSU in office or via email: coordinator@ksu.ca