**KSU HEALTH AND DENTAL PLAN**

By using the collective buying power of our members, and of students across Canada, the King’s Students’ Union is able to offer affordable extended health and dental coverage to all students at King’s. The plan is administered by the King’s Students’ Union.

Students enrolled in this year’s plan are eligible to receive reimbursement on drug paramedical, dental and other medical expenses from September 1, 2024 until August 31, 2025. This form allows for students with family members or other dependents that they wish to include on their plan to enroll.

*To opt a dependent into the plan please fill out this form, attach payment and return it to the KSU Services and Campaigns Coordinator, in the King’s Students’ Union Office. Please use a separate form for each dependent you wish to add to your coverage. Questions can be directed at coordinator@ksu.ca.*

**DEPENDENT ELIGIBILITY**

To be eligible for coverage, a dependent must be:

* An unmarried child that is under the age of 21; and a child who resides with you in a parent-child relationship and/or is dependent upon you, and not regularly employed; **OR**
* An unmarried child who is under age 25 and enrolled in full-time attendance at an accredited college, university or educational institute; **OR**
* An unmarried child of any age, who is disabled by reason of mental or physical disability; **AND**
* A Canadian resident covered under a provincial health insurance plan; and

**PAYMENT**

Fees to add a dependent to the Health and Dental Plan for the 2024-2025 academic year are as follows:

| **Health Plan and Dental Plan** | $363.00 |
| --- | --- |
| **Health** | $270.48 |
| **Dental** | $92.52 |

We accept payment via cheque or Interac e-Transfer with the email fvp@ksu.ca. For cheques, please address it to the King’s Students’ Union with your name and student ID number (B00 number) in the memo field and submit it to the King’s Students’ Union Services and Campaigns Coordinator with this form.

**REQUEST FOR ADDITION OF DEPENDENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request the addition and or continuation of coverage of  
 (your name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a dependent to my KSU Health and Dental Plan Coverage.  
 (your dependent’s name)

Dependent date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please answer the following:*

1. A) This child is under 21, resident with me and domiciled in my home.

YES\_\_\_ NO\_\_\_\_

**OR**

1. B) This child is mentally or physically handicapped and an amount for an infirm dependent age 18 or over can be claimed by me under the Income Tax Act. YES\_\_\_ NO\_\_\_\_

**OR**

1. C) This child is enrolled and in full-time attendance at a college, university, or institute of higher learning and meets the age requirements of the group contract.   
   YES\_\_\_ NO\_\_\_\_

**AND**

1. This child is unmarried, unemployed and financially dependent upon me.   
   YES\_\_\_ NO\_\_\_\_

By signing this form I agree that the information provided is complete and accurate to the best of my knowledge. Failure to disclose or falsifying information could result in denial of claims and the cancellation of my coverage.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Plan Member

DATED THIS \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_ 2024.

**Plan Member Information**

Student ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Province \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependent Information**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Time Student: \_\_\_\_\_\_ YES \_\_\_\_\_\_\_NO

Disabled Dependent: \_\_\_\_\_\_YES \_\_\_\_\_\_\_ NO

By signing this form, I confirm that the information is complete and accurate to the best of my knowledge. I am authorized to release information concerning my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I agree that the King’s Students’ Union’s Health and Dental Plan provider, Green Shield Canada may share the personal information with a third party for the administration of benefits for myself and my dependents. I agree that Green Shield Canada may use my email address, if provided, to correspond with me for benefit purposes (note that emails are not used for solicitation purposes).

Plan Member’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Administrator’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_