**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 spouse 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. Questions can be directed to coordinator@ksu.ca.*

**SPOUSE ELIGIBILITY**

To be eligible for coverage, a spouse must be:

* A Canadian resident covered under a provincial health insurance plan; and
* Legally married to you or, if not legally married, have lived in a common-law
relationship with you for more than 12 continuous months.

**PAYMENT**

Fees to add a spouse for 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 SPOUSE**

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

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

Spouse date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please answer the following:*

I am legally married to my spouse or, if not legally married, I have lived in a common-law relationship with the plan member for more than 12 continuous months.

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.

**FOR OFFICE USE ONLY**

| **Date Received:** | **Client ID Number:**  |
| --- | --- |
| **Billing Division:**  | **GSC ID Number:**  |

 **Plan Member Information**

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

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

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

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

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

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

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

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

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

**Spouse Information**

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

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

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

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

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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