Roman Catholic Archbishop of Vancouver

EMPLOYEE BENEFIT PROGRAMME

Student Recertification Form

IMPORTANT! The following form is to be completed in full by the Employee. Failure to complete this form and return it to the Benefits Administration Office within thirty-one (31) days from the date you were contacted for dependent student information will result in termination of coverage for this dependent as of their birth date.

The definition of a dependent student is as follows:

- Dependent is between the ages of 22-25;
- Registered as a full-time (FT) student in a recognized post-secondary school;
- FT is defined as 15 hours per week of in-class study;
- The student cannot be paid to attend school;
- The student can have a part-time (PT) job; however he/she can't work more than 30 hours per week; and,

Providing the employee has family coverage; and their child meets **ALL** of the aforementioned criteria, then the dependent can remain on their parents plan.

I. Plan member's information

Employee's Name: _____

Employee ID Number: _____ Employer Number: _____

Employer Name: _____

Policy Number(s): **Extended health: 335645 / Dental: 56565**

II. Dependant Student's Information

Name of Dependent: _____

Date of Birth: _____ Full-Time Student? ☐ Yes ☐ No

Student ID number: _____ Semester(s) attending: _____

Name of accredited post-secondary school: _____

Address of accredited post-secondary school: _____

Contact Number: _____ Fax Number: _____

Student Employed? ☐ Yes ☐ No | How many hours does the dependent work/week: _____

III. Authorization

I hereby request that the dependent named above remain covered on my extended health and/or dental insurance policies. I certify that this dependent is an unmarried child and currently attending an accredited post-secondary school. I certify that under penalty of perjury insurance fraud, that all statements contained in this certification are true to the best of my knowledge.

EmployEE Signature: _____ Date: _____

EmployER Signature: _____ Date: _____

(Date Received by Benefits Administration Office: _____ **)**

Return this form to:
Benefits Administration Office
4885 Saint John Paul II Way, Vancouver, BC V5Z 0G3