Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

OVER-AGE DEPENDENT DECLARATION

Send form to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

1) INSTRUCTIONS

This form is to be completed by the employee to inform Health Risk Services of any over-age dependents who are currently enrolled full-time in post-secondary institutions. Failure to complete and return this form annually will result in the dependent being terminated from the plan. An over-age dependent is any dependent over the age of 21, but under the age of 26.

Regardless of post-secondary status, no dependent over the age of 25 is eligible under the plan.

2) EMPLOYEE INFORMATION

Full Name:	DOB: MM/DD/YYYY	Employer:	Group Number:	ID Number:
Address:		City:	Province:	Postal Code:

3) DEPENDENT INFORMATION

DEPENDENT FULL NAME	DATE OF BIRTH (MM/DD/YYYY)	NAME OF EDUCATIONAL INSTITUTION	START OF SCHOOL TERM (MM/DD/YYYY)	END OF SCHOOL TERM (MM/DD/YYYY)

4) ACKNOWLEDGEMENT AND CONSENT

- I agree that a photocopy or electronic copy of the Authorization and Declarations section is as valid as the original.
- I give permission to Health Risk Services Inc. to continue educating me regarding my benefits program and/or any additional products and services available to myself and my family through Health Risk Services. I am aware that this information may be forwarded through my employer, to my personal residence or by personal/business emails that have been provided.
- I have included documents from my dependents Educational Institution stating they are enrolled in, and currently attending full-time studies.

BY INITIALING HERE, I HEREBY AUTHORIZE:

☐ **Initials**

Health Risk Services, any healthcare provider, my plan administrator, other insurance or re-insurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with Heath Risk Services to exchange personal information, when necessary to determine my eligibility for coverage and to continue to administer the plan.

I certify that all information I have given is true, correct and complete to the best of my knowledge. I understand that the submission of fraudulent information is a criminal offence. Suspected fraudulent activity may be reported to the employer/plan sponsor and to the appropriate law enforcement agency.

5) EMPLOYEE SIGNATURE

Authorized Signature:	Date Signed (MM/DD/YYYY):