



Kinectrics Inc.

Health & Dental Enrollment - Over Age Dependent

Great West Life Policy Number: 51597

Employee/Pensioner Information

Employee Number

_____|_____|_____|_____|_____|_____|

Coverage Category
(S - single, F - family)

_____|_____|

Employee Last Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

First Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Initial

_____|_____|

Apt No.

_____|_____|_____|

Street Address

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

City

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Province

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Postal Code

_____|_____|_____|_____|_____|_____|

Gender
(M or F)

_____|_____|

Date of Birth

(month/day/year)

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Marital Status

Single

Divorced

Married

Widowed

Common-Law

Legally Separated

Dependent Child Information

Child's Last Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

First Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Initial

_____|_____|

Gender
(M or F)

_____|_____|

Child's Date of Birth

(month/day/year)

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Age

_____|_____|

Relationship to Employee

S - Son D - Daughter O - Other

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Full-Time Student

Y or N

_____|_____|

Disabled Dependent

Y of N

_____|_____|

Name and Address of School

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Child's Last Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

First Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Initial

_____|_____|

Gender
(M or F)

_____|_____|

Child's Date of Birth

(month/day/year)

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Age

_____|_____|

Relationship to Employee

S - Son D - Daughter O - Other

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Full-Time Student

Y or N

_____|_____|

Disabled Dependent

Y of N

_____|_____|

Name and Address of School

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Child's Last Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

First Name

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Initial

_____|_____|

Gender
(M or F)

_____|_____|

Child's Date of Birth

(month/day/year)

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Age

_____|_____|

Relationship to Employee

S - Son D - Daughter O - Other

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Full-Time Student

Y or N

_____|_____|

Disabled Dependent

Y of N

_____|_____|

Name and Address of School

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Certification

I hereby certify that the information contained is accurate. I acknowledge that any deliberate falsification may result in the re-payment of more money received for ineligible claims, legal action, and for employee's disciplinary action up to and including termination of employment. I also acknowledge approval that Great-West Life may cross reference medication to ensure drugs purchased by individuals covered under Kinectrics Inc.'s Plan from different pharmacies, are compatible, and understand that this information will be treated as confidential by Great-West Life.

Employee/Pensioner Signature

Date

Instructions: Return original copy to the Kinectrics Benefits Centre, P.O. Box 7650, Station B, Toronto, ON M2K 3B5. Keep a copy for your files.





Kinectrics Benefits Centre

Eligible Dependents

Eligible Children

To be eligible for continued coverage after their 19th birthday, dependent children must be:

- unmarried **AND** unemployed **AND** attending school full-time up to and including 23 years of age.

Coverage ceases as of the child's 24th birthday or if any of the other above criteria are not satisfied.

Children includes:

- any child of the employee/pensioner or their spouse and legally adopted children;
- a child of any age who is dependent for financial support upon the employee/pensioner or the Employee's/Pensioner's spouse because of physical or mental infirmity, provided infirmity commenced while the individual otherwise met the definition of an eligible child as outlined above.

Note: It is the responsibility of the employee/pensioner to notify the Kinectrics Benefits Centre of any addition or deletions when a dependent no longer meets the eligibility criteria, or when spousal coverage under another benefits plan changes.