

**SECTION 1**

<b>CONTRACT NO.</b> _____ - _____	<b>GENDER</b> M <input type="checkbox"/> F <input type="checkbox"/>	I DECLARE THAT ALL ATTACHED EXPENSES HAVE BEEN INCURRED FOR: MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY DEPENDENT CHILDREN (INDICATED BELOW) <input type="checkbox"/>																
<b>NAME OF PARTICIPANT:</b> _____		<b>If your child is studying full time, complete Section 3 below.</b> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:70%;"></th> <th colspan="3" style="text-align:center">DATE OF BIRTH</th> </tr> <tr> <th style="text-align:center">FIRST NAME</th> <th style="text-align:center">Y</th> <th style="text-align:center">M</th> <th style="text-align:center">D</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		DATE OF BIRTH			FIRST NAME	Y	M	D								
	DATE OF BIRTH																	
FIRST NAME	Y		M	D														
<b>ADDRESS:</b> _____																		
<b>POSTAL CODE:</b> _____	ARE THESE EXPENSES COVERED UNDER <b>ANOTHER INSURANCE CONTRACT?</b> NO <input type="checkbox"/> YES* <input type="checkbox"/> * IF YES, COMPLETE SECTION 2 BELOW.																	
<b>TOWN/CITY:</b> _____	ARE THESE EXPENSES THE RESULT OF A <b>WORK ACCIDENT?</b> NO <input type="checkbox"/> YES <input type="checkbox"/>																	
<b>PROVINCE:</b> _____	ARE THESE EXPENSES THE RESULT OF AN <b>AUTOMOBILE ACCIDENT?</b> NO <input type="checkbox"/> YES <input type="checkbox"/>																	
<b>COVERAGE STATUS:</b> FAMILY <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SINGLE-PARENT <input type="checkbox"/> COUPLE <input type="checkbox"/>																		
<p style="text-align:center"><b>IMPORTANT</b></p> Complete this coupon and attach your receipts. Please send only original copies of receipts or paid invoices. Please keep a copy of all documents sent as receipts will not be returned. You are invited to file your claims at regular 3-month intervals.																		
_____ <small>DATE</small>		_____ <small>TELEPHONE NO.</small>																
_____ <small>DATE</small>		_____ <small>SIGNATURE OF PARTICIPANT</small>																

**SECTION 2**

<b>TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER</b>								
_____ <small>NAME OF POLICYHOLDER</small>	<table style="width:100%; text-align:center;"> <tr> <td>Y</td> <td>M</td> <td>D</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> <small>DATE OF BIRTH</small>	Y	M	D				<b>COVERAGE STATUS</b> FAMILY <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SINGLE-PARENT <input type="checkbox"/> COUPLE <input type="checkbox"/>
Y	M	D						
_____ <small>NAME OF OTHER INSURER</small>	_____ <small>CONTRACT NO.</small>							

**SECTION 3**

<b>TO BE COMPLETED FOR AN OVERAGE DEPENDENT IF UNMARRIED AND STUDYING FULL TIME</b>		
I DECLARE THAT MY CHILD _____, BORN ON _____,		
<small>NAME OF CHILD</small>		
IS UNMARRIED AND IS ENROLLED AT THE HIGH SCHOOL, COLLEGE OR UNIVERSITY _____		
<small>NAME OF SCHOOL, COLLEGE OR UNIVERSITY</small>		
AS A FULL-TIME STUDENT FOR THE 20____ - 20____ ACADEMIC YEAR, AND IS FOLLOWING A COURSE OF STUDY IN _____		
_____		
_____ <small>DATE</small>	_____ <small>SIGNATURE OF PARTICIPANT</small>	