Over age dependant application

people CORPORATION®
Experience the Benefits of People

Submit via email: adminsupport@peoplecorporation.com
Submit via mail: 1403 Kenaston Blvd., Winnipeg MB R3P 2T5
Submit via fax: 204-488-6008 **Claim inquiries:** 1-800-875-7982

Plan member information

Division name: _____

Plan member name: _____ Certificate #: _____

Dependant information

Dependant name: _____

Dependant date of birth (DD/MM/YYY): _____

Is the over age dependant employed? ☐ Yes ☐ No If yes, how many hours per week? _____

Is the over age dependant attending college or university? ☐ Yes ☐ No

If yes, please provide the following information:

Name and location of college or university: _____

Program of study: _____

Duration of program (MM/YYYY): From: _____ To: _____

Student number: _____

If the over age dependant is **not** attending college or university, is the over age dependant suffering from a severe, incurable, and chronic physical or mental disability which has resulted in you being fully responsible for their financial, mental and/or physical well-being? ☐ Yes ☐ No

If yes, please provide a letter from your medical doctor detailing the disability. Include details of onset, full diagnosis, prognosis, and information regarding the amount of care required.

Attestation and signature

I certify that all information in this form is true and accurate. I authorize People Corporation, any insurance companies and healthcare providers to exchange information when necessary to determine eligibility and to administer the plan. I understand that it is my responsibility to provide any additional information or proof that may be requested or deemed necessary. I acknowledge that I only enrol, at this time or any future time, dependants that have authorized me to provide their information and consent to the collection, use and disclosure of their information for the above purposes. I have the right to request access to the Personal Information in my file and where appropriate to have inaccurate information corrected. A photocopy or electronic copy of this authorization will be as valid as the original.

Plan member signature _____ Date signed (DD/MM/YYYY) _____