

# Application for Dependent Coverage



for International Students

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.  
Call 1-800-891-0370 for a copy of the **ets** Privacy Statement. For Privacy Information, please see [www.rsagroup.ca](http://www.rsagroup.ca), or call us at 1-800-716-4339.

20 31 APS ECA 0609 DEP

## STUDENT INFORMATION

F  
 M

Student ID #: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Country of Origin: \_\_\_\_\_ Date of Birth (D/M/Y): / / Date of Arrival in Canada (D/M/Y): / /

Address in Canada: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Course: \_\_\_\_\_ Period of Study (D/M/Y): \_\_\_\_\_ to (D/M/Y): \_\_\_\_\_

## DEPENDENT INFORMATION

Spouse:  Legally married  Residing together for at least the last 12 months Date of Arrival in Canada (D/M/Y): / /

LAST NAME	FIRST NAME	DATE OF BIRTH (D/M/Y)	SEX
Spouse: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>

If additional room is required, please attach a separate page.

## MEDICAL INFORMATION

To the best of your knowledge are you and your dependents in good health?  Yes  No

If No, what type of medical treatment or hospitalization do you or they require? (Attach additional information to the back of this application.)

Are any dependents currently pregnant?\*  Yes  No If Yes, please provide the expected due date: \_\_\_\_\_

\* Please note that a pregnancy will not be covered unless you were insured at the time the pregnancy commenced, provided you paid the FAMILY RATE (note that the rate for your Spouse or 1 Child **does not** cover maternity benefits).

**Post-Secondary Program**

Monthly Premium		
Months	Spouse or 1 Child	Family
12	\$370	\$740
11	\$366	\$732
10	\$355	\$670
9	\$305	\$610
8	\$274	\$548
7	\$243	\$486
6	\$213	\$426
5	\$179	\$358
4	\$145	\$290
3	\$111	\$222
2	\$74	\$148
1	\$37	\$74

Premium per Session		
Sessions	Spouse or 1 Child	Family
September 1 to August 31	\$370	\$740
January 1 to August 31	\$274	\$548
May 1 to August 31	\$145	\$290

**ESL Program**

Monthly Premium	
Spouse or 1 Child	Family
\$48	\$96

\* Multiply the number of months by \$48 or \$96 to calculate the premium.

**INSURANCE PERIOD and PAYMENT MODE**

Desired Effective Date (D/M/Y): / / | Termination Date (D/M/Y): / / | Number of months or days of coverage: | Total Premium Due: \_\_\_\_\_

 Certified Cheque / Money Order (Please make payable to **etfs**.) Visa       Master Card       Diners       American Express

Credit Card Number: \_\_\_\_\_ Expiry Date (M/Y): \_\_\_\_|\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

**MEDICAL AUTHORIZATION and DECLARATION**

I understand that I must purchase the policy within 30 days from the date of my arrival in Canada, otherwise any pre-existing medical condition will not be covered. I understand that if I am presently insured under an insurance policy administered by **etfs**, I must pay the insurance premium prior to the termination date of my existing policy. If I do not satisfy the above conditions, I understand that I will not be covered for a sickness occurring during the first 30 days of this insurance coverage.

I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. may investigate my claim. By signing this application, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.

Student's Signature: \_\_\_\_\_ Date (D/M/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date (D/M/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

**DEFINITIONS**

**"Child(ren)"** means an unmarried child of the student or his/her spouse, who is dependent on the student for support, provided that such child is between 15 days and 20 years of age on the date of application; or

**"Spouse"** means the person, who is less than 65 years of age, to whom the student is legally married or with whom the student has been residing for at least the last 12 months.

**Please return your completed form and payment to the Student Health Benefits Office of George Brown College.**

**FOR OFFICE USE ONLY**

Effective Date (D/M/Y): / / | Policy Number: | Student ID #: \_\_\_\_\_

Expiry Date (D/M/Y): / / | Premium Paid: |  30-Day Penalty

Underwritten by:

Administered by:



Student Association of George Brown College Health and Hospitalization Insurance for International Students is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by Expert Travel Financial Security (E.T.F.S.) Inc.

™ "RSA" and the RSA logo are trademarks owned by RSA Insurance Group plc, licensed for use by Royal & Sun Alliance Insurance Company of Canada.

© The **etfs** logo is a registered trademark of Expert Travel Financial Security (E.T.F.S.) Inc.