FORM 03

Dependant Information & Over Age Dependant Form

Please complete all information requested below, sign and return to:
AFBS, 1000 Yonge Street, Toronto, Ontario M4W 2K2

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416-967-6600 1-800-387-8897
FAX: 416-967-4744 1-888-804-8929
E-MAIL: benefits@afbs.ca

AFBS WEST: 320 -1155 Pender Street West
Vancouver, BC V6E 2P4
PHONE: 604-801-6550 1-866-801-6550
FAX: 604-801-6580
E-MAIL: afbswest@afbs.ca

SECTION 1 – Member Information *(please print)*

Member Name (Last, First, Middle Initial)	Telephone Number	Date of Birth

Your Account Number	ACTRA/WGC Number (if applicable)
4501 ☐☐☐☐☐☐	

I participate in the following program (check one):

☐ AFBS Members' Insurance Program ☐ Employer Benefits Program ☐ Writers' Coalition Program ☐ Arts & Entertainment Plan®

☐ Other _____

ADDING DEPENDANTS

☐ I currently provide dependant coverage and am adding a new dependant, as indicated in *SECTION 2*, at this time.

☐ I wish to insure my eligible dependant(s), as indicated in *SECTION 2*, who recently lost coverage elsewhere.

Insurance Company	Group Policy #	Identification or Certificate #

Employer, Association or Organization who provided these benefits	Date benefits terminated

☐ I wish to insure my dependant(s) as indicated in Section 2 who became eligible on Date _____

as a result of the following 'life event': _____

If you are under age 65, you have the option to insure your eligible dependant(s) immediately when a 'life-event' occurs. **AFBS must be notified within 45 days of the 'life event' occurring or at some later date. However, if outside the 'life-event' period of 45 days, a 6-month waiting period may apply.** Benefits will be effective from the first of the month following notification subject to receipt of the applicable premium due.

Typical 'life-events' include:
- Acquiring a spouse/partner;
- Dependant(s) insured elsewhere losing their access to similar benefits;
- Birth or adoption of a child. Newborns are eligible for coverage on the later of 15 days of age or the date of discharge from hospital.

TERMINATING DEPENDANT COVERAGE

☐ The individual(s) indicated in *SECTION 2,* is/are no longer dependant(s) and should be removed from my AFBS coverage.

☐ The individual(s) indicated in *SECTION 2,* has/have attained similar coverage elsewhere and should be removed from my AFBS coverage.

Insurance Company	Group Policy #	Identification or Certificate #

Employer, Association or Organization who provided these benefits

If removing dependants results in a change to your insurance to Member-only coverage, premium will be adjusted from the first of the month following receipt of your notification. Any premium credit will be returned to your Insurance Account.

Underwritten by:
Actra Fraternal Benefit Society: 1000 Yonge Street, Toronto, Ontario M4W 2K2
Telephone: (416) 967-6600 / Toll Free: 1-800-387-8897 Fax: (416) 967-4744 / Toll Free Fax: 1-888-804-8929
E-mail: benefits@afbs.ca Website: www.afbs.ca

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SECTION 2 – Dependant Information *(please print)*

Full Name of Dependant	Relationship	Date of Birth
Full Name of Dependant	Relationship	Date of Birth
Full Name of Dependant	Relationship	Date of Birth
Full Name of Dependant	Relationship	Date of Birth

FOR INSURANCE PURPOSES ONLY, **"DEPENDANTS"** ARE:

a) Your spouse/partner (legal or common law) who is living with you. "Common law partner" means a person who is publicly represented as being your spouse/partner and who has been living with you continuously for at least 2 years (except where otherwise required by provincial legislation).

b) Any unmarried natural child or stepchild or legally adopted child or grandchild of yours who is living with you and for whom you have contributed the major amount of support, and who is:

(i) under 18 years of age and living at your home; or

(ii) between the ages of 18 and 26 (coverage ceases on the dependant's 26th birthday) and attending a recognized college or university on a full-time basis (please complete Over Age Dependant information below); or

(iii) over 18 years of age who is, and continues to be, incapable of self-sustaining employment because of a handicap or disability. (Physician letter required)

SECTION 3 – Over Age Dependant Information *(please print)* Annual reconfirmation will be required

Please provide information as appropriate based on the definition above:

First Name	Name of College/University	Conclusion of Studies Date (if applicable)	Check if handicap or disability
			☐
First Name	Name of College/University	Conclusion of Studies Date (if applicable)	☐
First Name	Name of College/University	Conclusion of Studies Date (if applicable)	☐

Consent

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that the purpose of providing this information to AFBS is to assist with the accurate administration of my Extended Health Care and dental benefits as well as those of any insured dependants. I further understand that AFBS is providing this information to ClaimSecure, or successor provider of electronic claims processing, to assist with the adjudication of on-line claims submissions and claims processing and agree to this use of the information provided. I understand that I am responsible for advising AFBS within 45 days of any change to this information and that failure to make such notification, in writing, may jeopardize both my claims and those of my dependants. A photocopy of this authorization is as valid as the original.

Member's Signature (required)	Date

AFBS is committed to protecting the confidentiality of the personal information we collect from you. We will use this information to revise your insurance benefits as indicated by you, and to assess the eligibility of Extended Health Care and dental claims submitted by you on behalf of your dependants under the AFBS Members' Insurance Program.

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