the co-operators
A Better Place For You™

DECLARATION OF STUDENT ELIGIBILITY

INSTRUCTIONS

1. Please print clearly.
2. Please complete Part 1 & Part 2
3. The declaration must be signed and dated.
4. Please forward completed forms to your Employer.

PART 1. - EMPLOYEE/MEMBER INFORMATION

Employee/Member's Name _____

Group Policy No. **G.3600** Account No. **N/A** PID No._____

PART 2. - DEPENDENT INFORMATION

Please complete the following questions:

1. Dependent Student's Name _____ Date of Birth ____/_____/____

2. Name of School in attendance _____

   Address _____

   Phone No. of Registrar's office ( ) _____- _____ Fax. No. ( ) _____- _____

3. Student Status ❑ Part-time ❑ Full-time ❑ Correspondence

4. Student is enrolled in the semester starting _____/_____/_____ and ending _____/_____/_____
   DD MM YY DD MM YY

5. Will student be graduating at the end of the semester indicated above? ❑ Yes ❑ No

NOTE: Declaration MUST be provided prior to each semester the dependent attends school.

DECLARATION

I hereby certify that the above information is true and complete and authorise the educational institution shown to release full information regarding my dependant's enrolment, to the Co-operators Life Insurance Company.

Employee/Member's Signature **X**_____ Date **X**_____