APPLICATION FOR HEALTH CARE COVERAGE - OVER AGE DEPENDENT CHILDREN
de Havilland Inc./BRAD Division

OVERAGE DEPENDENT STATUS

Name of child:_____

Date of Birth:_____Male_____Female_____

Student's SIN:_____

Is your marital status single? Yes_____No_____

Are you fully dependent on parents for tax purposes? Yes_____No_____

Name of School of Attendance:_____

Address of School:_____

Is attendance on a full-time basis? Yes_____No_____

Please indicate the expected duration of the course:

a) 1 year_____b) Semester basis_____c) Other (please specify)_____

_____

Start Date:_____Expected Graduation Date:_____

Permanently and totally disabled? Yes_____No_____

NOTE: If yes a Doctor's letter **must** accompany the application confirming the dependent child's total disability.

I, the overage dependent, verify that the above information is correct.

Signature of Dependent:_____Date:_____

Signature of School Registrar:_____Date:_____

SCHOOL SEAL

I, the employee, hereby certify that my above-named child is unmarried, currently residing with and wholly dependent upon me. Further, that I am claiming the child as a dependent for Income Tax purposes in the current year. (If not, please explain below.) I also agree to notify the Employee Benefits Coordinator, in writing, immediately if my above-named child ceases to be dependent upon me, changes residence to another other than my own, marries or is otherwise no longer qualified to be considered my dependent.

Employee's Comments:_____

Employee's Name:_____Clock #:_____Dept. #:_____

Employee Signature:_____Local 112___Local 673___Salaried_____

N.B. Any false statement can be construed as misrepresentation and could lead to discipline and termination of employment.