NOVA SCOTIA
Public Service Commission

Over Age Dependent Application for Health and Dental Coverage– Province of Nova Scotia (Member Employer)

Instructions: To continue Health and Dental coverage for your Student Dependent(s), age 21 up to and including age 24, who is/are unmarried, unemployed, and attending an accredited school, college or university on a full-time basis, complete all fields and sign this form.

Electronic copies are acceptable.

Section 1: Employee/Retiree Information

Employee/Retiree ID #	Date of Birth (DD/MM/YY)	Phone Number
Last Name	**First Name**	**Initial**

Section 2: Student Dependent Information

Dependent Last Name	Dependent First Name	Date of Birth	Name of Accredited School/College/University	Begin School Term (DD/MM/YY)	End School Term (DD/MM/YY)

Section 3: Declaration and Authorization

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am eligible member, to recommend suitable products and services to me, and to manage Blue Cross' business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits consenting or refusing to consent to its disclosure. I certify that all information contained herein is correct and hereby authorize payroll deductions, if required. I certify that I am authorized to release information concerning my dependents, for the purposes of administering and managing the benefit plan. A photocopy of this authorization shall be valid as the original. The consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medaviebc.ca or call 1-800-667-4511.

Employee Signature	Date (DD/MM/YYYY)

Important Information:

An Over Age Dependent Application is required each school year for eligible dependents. If an Over Age Dependent Application is not received, coverage is terminated for dependents age 21 and over.

This form is used for the sole purpose of the Group Health and Dental Plan and does not apply to any other benefits offered by the Employer.

Please contact your employer if you have any questions.