ARM DENTAL PLAN (CONTRACT NUMBER Q1090) OPT-OUT & ENROLMENT FORM

RESET

For more information: www.studentcare.ca

1 INFORMATION TO BE COMPLETED BY HUMAN RESOURCES

Hospital	Effective Date of Coverage or Modification (MM/DD/YYYY)
New Plan Member ☐ Modification ☐	Billed: Single ☐ Couple ☐ Family ☐

2 PLAN MEMBER DETAILS

Employee Number	Last Name	First Name	Sex	Date of Birth (MM/DD/YYYY)
0 0 0 0			M ☐ F ☐	

Address	City	Province	Postal Code

Phone Number	Email Address

Coverage chosen:
Opt out ☐ Single ☐ Couple (1 dependant) ☐ Family (2 or more dependants) ☐

3 OPTING OUT

You may opt out of the Plan by selecting the box below:

I choose to opt out ☐

Note that opt outs are permanent, which means that you will remain opted out for the duration of your time as a resident at McGill. If you wish to re-enrol in the future, you will need to inform your payroll contact and fill out the form accordingly.

AUTHORIZATION & SIGNATURE FOR OPTING OUT – SIGN THIS SECTION ONLY IF YOU ARE OPTING OUT

I declare that the information above is accurate and true. A photocopy or electronic version of this authorization is as valid as the original. I hereby decline the Dental Plan provided by my association. I understand that the Plan I am declining to participate in may not be identical to the Plan in which I am currently enrolled. I also understand that I may be eligible to claim and combine benefits under both plans if I choose not to decline the coverage offered by my student association.

I understand that by changing my coverage, I absolve the insurance company, ARM, Studentcare, and any other party involved of all liability whatsoever for any loss suffered by myself and/or all of my dependants. I am responsible for familiarizing myself with the Plan before modifying my coverage.

☐ I would like my name, email, and address to be used by Studentcare to inform me about other insurance products and services specially developed for students. I understand that I can withdraw this consent at any time.

Signature	Date (MM/DD/YYYY)

4 ENROLLING A SPOUSE – COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR COVERAGE FOR YOUR SPOUSE

IMPORTANT: A spouse must first claim from their own employer's plan.
Spouse: The person who is your spouse by marriage or under any other formal union recognized by law, or your partner who has been publicly represented as your spouse for at least the last year.

Last Name	First Name	Sex	Date of Birth (MM/DD/YYYY)
		M ☐ F ☐	

ENROLLING CHILDREN – COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR COVERAGE FOR YOUR CHILD(REN)

IMPORTANT: Claims for your children must be sent first to the plan of the parent whose birth date falls earlier in the year.
Children: Your children and your spouse's children (other than foster children) are eligible dependants if they are not married or in any other formal union recognized by law and are under the age of 22. A child, who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependant until the age of 26 as long as the child is entirely dependent on you for financial support. You need to provide proof of the child's full-time status. If your child is over 21 years old, is disabled and is entirely dependent on you for financial support, they are eligible.

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Child's Name (Last, First)	Date of Birth (MM/DD/YYYY)	Sex	Student	Disabled Child
		M ☐ F ☐	Yes ☐ No ☐	Yes ☐ No ☐
		M ☐ F ☐	Yes ☐ No ☐	Yes ☐ No ☐
		M ☐ F ☐	Yes ☐ No ☐	Yes ☐ No ☐

ENROLMENT PREMIUMS & INFORMATION

AMOUNT FOR SELF-ENROLMENT
Self-enrolment: $332.60
Self-enrolment and payment are automatic; no form or cheque are required.
This amount is paid in installments directly on the resident's pay.

AMOUNT FOR FAMILY ENROLMENT
1 Dependant: $332.60
2+ Dependants: $665.20

Send the enrolment form and payment by mail to 1200 McGill College Avenue, Suite 2200, Montreal (QC), H3B 4G7.

When submitting this form **for an enrolment**, include a cheque or money order payable to Studentcare for the amount applicable written above. Please write your ID number in the "memo" section on the cheque or money order.

Any request to cancel this enrolment must be made within the Change-of-Coverage and Opt-Out Period. No enrolment reimbursement will be issued after this period. Please note that a $25 administration fee will be deducted from the amount to be refunded.

Coverage Period:
Coverage is valid from July 1, 2023 to June 30, 2024.

5 AUTHORIZATION & SIGNATURE FOR ENROLMENTS – SIGN THIS SECTION ONLY IF YOU ARE COMPLETING AN ENROLMENT

I understand that the coverage of my spouse/dependents is contingent upon my enrolment in the Plan. If I cease to be eligible for the Plan, then my dependents' coverage will be terminated.

I am authorized to disclose information about my spouse and/or dependents for the purpose of enrolling them in the Plan.

By enrolling in this Plan, I authorize the following:

- Desjardins Financial Security Life Assurance Company, its agents and service providers to use the information on this form to underwrite, administer, and pay claims.
- Studentcare and its agents to use the information on this form for benefits administration under this Plan and any other services provided to me by them.

☐ I would like my name, email, and address to be used by Studentcare to inform me about other insurance products and services specially developed for students. I understand that I can withdraw this consent at any time.

Signature	Date (DD/MM/YYYY)