Student Benefits Opt-Out Form

This opt-out form is to be used by students who have been enrolled in their student organization's health and/or dental plan(s) administered by Gallivan & Associates Student Networks (G&A), but wish to opt-out of the coverage for such plan(s) because he/she currently has comparable coverage. ***Please complete this form and submit it along with confirmation of existing coverage*** to the Student Benefits Plan Office. The opt-out form along with confirmation of coverage specific to health and/or dental must be received by the **APPLICABLE DEADLINE.** This opt-out period has been agreed upon by the student organization. **NO EXCEPTIONS WILL BE MADE.**

Opt-out forms can be submitted during the opt-out period associated with the start of your program or during the opt-out period associated with the start of the policy anniversary (ie. September 1st). **In either instance the opt-out form must be submitted prior to the appropriate deadline in order to be considered.**

PLEASE NOTE: For the student's convenience, after the initial opt-out form is processed, the student is automatically opted out each subsequent school year as long as you remain an eligible student (please contact the Student Benefits Plan Office for the definition of "eligible student"). If you lose the comparable coverage used to opt-out the health and/or dental plan(s), you must notify the Student Benefits Plan Office within 30 days to be covered by the Student Benefits Plan.

INCOMPLETE OPT-OUT FORMS INCLUDING THOSE SUBMITTED OR FAXED WITHOUT CONFIRMATION OF EXISTING COVERAGE WILL NOT BE PROCESSED.

Confirmation of existing coverage must show the name of the insurance company providing coverage and the policy number. The easiest way for you to provide confirmation of coverage is by presenting a copy of a benefits card or a confirmation letter from the employer/insurance company. Confirmation may also be provided by presenting other documents such as a recent statement of claim, web page print-out or other insurance company document identifying you, the insurer and the policy number.

Once we confirm coverage, we DO NOT retain any confirmation documentation that you provide to us.

STUDENT INFORMATION

Student ID _____ Name _____ Gender _____ Date of Birth (D D M M M Y Y) _____

Mailing Address _____ City/Province _____ Postal Code _____

Program Name _____ Program Start Date (D D M M M Y Y) _____

Email Address _____ Phone Number ( ) - _____

EXISTING COVERAGE INFORMATION

I have existing extended health coverage and wish to use that coverage to opt-out of the Student Extended Health Plan coverage.

☐ Yes ☐ No Insurer's Name _____ Policy Number _____

I have existing dental coverage and wish to use that coverage to opt-out of the Student Dental Plan coverage.

☐ Yes ☐ No Insurer's Name _____ Policy Number _____

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:

I wish to decline the student health and/or dental plan(s) coverage. Comparable health and/or dental coverage is presently provided for me under another insurance plan in addition to my provincial health care. I acknowledge that as a result of this opt-out, I forfeit all rights to coverage otherwise available to me under the student health and/or dental plan(s). I realize that I will not be able to rejoin the plan(s) until I enrol next year or unless I cease to be covered by my existing plan and apply within 30 days . I MUST visit the Student Benefits Plan Office to reinstate coverage. I understand that I would have been able to claim under my existing insurance as well as under the student health and/or dental plan(s), thereby increasing my coverage.

I understand that the information provided above is required in order for me to opt-out of the extended health and/or dental coverage. I hereby authorize and consent to the use, release and exchange of the above information between the educational institution, the student organization, Gallivan & Associates, third party service providers and the insurance carrier(s) to be used solely in connection with the administration of the Student Benefits Plan. I confirm that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Student Benefits Plan Office has received and approved my opt-out application.

Student Signature _____ Date (D D M M M Y Y) _____

YOU MUST SUBMIT THIS OPT-OUT PRIOR TO 4:00 p.m. ON THE ASSIGNED DEADLINE DATE

If you are not delivering this opt-out with your confirmation of coverage in person, please use the online opt-out (mystudentplan.ca) as you will receive a reply email confirmation.

OFFICE USE ONLY Processed Date (D D M M M Y Y) _____ Processed By _____

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GALLIVAN & ASSOCIATES STUDENT NETWORKS