DSU Health and Dental Benefits Opt In

This form is for coverage under the DSU Health and Dental Benefits only. If you or your dependents require primary care coverage you must complete an opt in form for the DSU International Student Plan.

Student Information

Student I.D.# B00_____ **Status:** ☐ Part-Time ☐ Co-Op/Work Term ☐ Exchange/Study Abroad ☐ International ☐ Summer ☐ Late Enrollment

Student's Name: _____ **Legal Sex:** ☐ Male ☐ Female

Date of Birth: _____ (Year Mo. Day) **Telephone #** ( )_____

The current age cap on the student plan is age 99 for Drug Coverage, age 70 for Extended Health, Dental, Travel & Accident Coverage.

Student's Personal E-mail Address: _____

Student's Address while at university: _____
(No./Street Apt./Unit# City/Town Prov. Postal Code)

Student's Permanent Home Province & Country: ☐ Same as Above **Or** ☐ Other: _____

Application for Coverage

Deadlines: 4:30pm on **Fall:** Sept. 17, 2021 **Winter:** Jan. 14, 2022 **Spring:** May 20, 2022

- Student health coverage automatically includes Student Accident Insurance provided by Chubb Insurance under Policy SG10458107
- Extended Health (including Emergency Travel) & Dental is administered by Medavie Blue Cross under Policy #0091936000

Request for Single Coverage

	☐ Single Health	☐ Single Dental	TOTAL
Fall (12 mths)	☐ $282.80	☐ $185.84	**$468.64**
Winter (8 mths)	☐ $282.80	☐ $185.84	**$468.64**
Spring (4 mths)	☐ $*156.21		**$156.21**

*There is no option to opt-in to either Health or Dental for Spring Term, student must enrol in both.
**Student must be enrolled with Single Coverage to enroll family members.

Request for Family Coverage**

Complete this section **only if** requesting additional coverage for spouse and/or dependent children. **Dependents must have proper provincial or comparable insurance to qualify.**

	☐ Family Health	☐ Family Dental	TOTAL
Fall (12 mths)	☐ $282.80	☐ $185.84	**$468.64**
Winter (8 mths)	☐ $282.80	☐ $185.84	**$468.64**
Spring (4 mths)	☐ $*156.21		

Dependent Information

Only complete if **Family** Coverage is requested, use additional sheets if necessary

- If dependent is over 21 but under 25, proof of full-time student status is required
- If relationship to student is common-law partnership, please provide date of cohabitation

Dependents First & Last Name	Legal Sex	Relationship to Insured Student *(include date of cohabitation if common-law)*	Date of Birth Yr.	Mo.	Day
	☐ Male ☐ Female				
	☐ Male ☐ Female				
	☐ Male ☐ Female				

Student Authorization:

I understand the information I provide on this form will be used by the DSU Student Health Plan Office and the financial services of the university for the purposes of administering my student health benefits. I also understand that relevant information may be exchanged with the applicable insurer and/or third party insurance administrator acting on behalf of the insurer, as deemed necessary for the purposes of administration of my student health benefits, validation of the status of my insurance coverage, and determining any eligibility for claimed benefits. I hereby authorize the DSU Student Health Plan Office to exchange any relevant and necessary information with such parties for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. Any true copy of this authorization shall be considered as valid as the original.

Student's Signature: _____ **Date** _____

Submit with Payment To: DSU Student Health Plan Office, Student Union Building, Dalhousie University, 6136 University Ave., Halifax, NS B3H 4R2
Debit or credit only.

Inquiries:

- If you have general questions regarding your student health benefits, inquire at the DSU Health Plan Office - Student Union Building 6136 University Ave., Halifax, NS B3H 4R2 Phone: (902) 494-2850 www.dsu.ca
- If you have specific, confidential questions about your application, call Student VIP at 1-888-918-5056, or e-mail info@studentvip.ca

DSU Health Plan Office Use Only

Date Application Received: _____ (Year Mo. Day) **Initials of Receiver:** _____ **Total Amount Paid:** _____

Application: ☐ Accepted ☐ Declined **Reason if Declined:** _____ **Payment Method:** ☐ Debit/Credit