



FORM 03WC
Dependant Information & Over Age Dependant Form

Your ACCOUNT NUMBER

4501						
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SECTION 1 - Member Information (please print)

MEMBER NAME (Last, First, Middle Initial)	DATE OF BIRTH	TELEPHONE NUMBER
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ADDING DEPENDANTS

- I currently provide dependant coverage and am adding a new dependant, as indicated in SECTION 2 below, at this time.
- I wish to insure my eligible dependant(s), as indicated in SECTION 2 below, who recently lost coverage elsewhere.

Insurance Company: _____ Group Policy #: _____ Identification or Certificate #: _____

Employer, Association or Organization who provided these benefits: _____ Date benefits terminated: _____

- I wish to insure my dependant(s) who became eligible on as a result of the following 'life event':

In order to provide dependant benefits, AFBS must be notified within 45 days of a 'life event' occurring when coverage for an eligible dependant is added. Benefits will be effective from the first of the month following notification. There is a 6 month waiting period if coverage for an eligible dependant is requested more than 45 days after a 'life event'.

TERMINATING DEPENDANT COVERAGE

Effective the 1st of the month following this notification to AFBS or the later date of

- The individual(s) indicated below in SECTION 2, is/are no longer dependant(s) and should be removed from my coverage.
- The individual(s) indicated below in SECTION 2, has/have attained similar coverage elsewhere and should be removed from my AFBS coverage.

Insurance Company: _____ Group Policy #: _____ Identification or Certificate #: _____

Employer, Association or Organization who provided these benefits: _____

If removing dependants results in a change to your insurance to single-only or couple coverage, premium will be adjusted from the first of the month following receipt of your notification. Any premium credit will be applied to future premium payments unless you specifically request that any credit be refunded to you. Please be advised that credits of less than \$20.00 cannot be refunded.

SECTION 2 - Dependant Information (please print)

FULL NAME OF DEPENDANT	RELATIONSHIP	DATE OF BIRTH
FULL NAME OF DEPENDANT	RELATIONSHIP	DATE OF BIRTH
FULL NAME OF DEPENDANT	RELATIONSHIP	DATE OF BIRTH
FULL NAME OF DEPENDANT	RELATIONSHIP	DATE OF BIRTH

Underwritten by:

Actra Fraternal Benefit Society: 1000 Yonge Street, Toronto, Ontario M4W 2K2
 Telephone: (416) 967-6600 / Toll Free: 1-800-387-8897 Fax: (416) 967-4744 / Toll Free Fax: 1-888-804-8929
 E-mail: writerscoalition@actrafrat.com Website: www.writerscoalition.com





FOR INSURANCE PURPOSES ONLY, "DEPENDANTS" ARE:

- a) Your spouse/partner (legal or common-law) who is living with you. "Common-law Partner" means a person who is publicly represented as being your spouse/partner and who has been living with you continuously for at least 2 years (except where otherwise required by provincial legislation).
- b) Any unmarried natural child or stepchild or legally adopted child or grandchild of yours who is living with you and for whom you have contributed the major amount of support, and who is:
 - i) under 18 years of age and living at your home; or
 - ii) between the ages of 18 and 26 and attending a recognized college or university on a full-time basis (please complete Over Age Dependant information below); or
 - iii) over 18 years of age who is, and continues to be, incapable of self-sustaining employment because of a handicap or disability.

SECTION 3 - Over Age Dependant Information (please print)

Please provide information as appropriate based on the definition above.

FIRST NAME	NAME OF COLLEGE / UNIVERSITY	<input type="checkbox"/>	CONCLUSION OF STUDIES DATE (if applicable)
FIRST NAME	NAME OF COLLEGE / UNIVERSITY	<input type="checkbox"/>	CONCLUSION OF STUDIES DATE (if applicable)
FIRST NAME	NAME OF COLLEGE / UNIVERSITY	<input type="checkbox"/>	CONCLUSION OF STUDIES DATE (if applicable)

Please check box in the area 'NAME OF COLLEGE/UNIVERSITY' if you are providing benefits for an Over Age Dependant under point iii) above.

CONSENT

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I understand that the purpose of providing this information to Actra Fraternal Benefit Society is to assist with the accurate administration of my Extended Health Care and dental benefits as well as those of any insured dependants. I further understand that Actra Fraternal Benefit Society is providing this information to ClaimSecure, or successor provider of electronic claims processing, to assist with the adjudication of on-line claims submissions and claims processing and agree to this use of the information provided. I understand that I am responsible for advising AFBS within 45 days of any change to this information and that failure to make such notification, in writing, may jeopardize both my claims and those of my dependants. A photocopy of this authorization is as valid as the original. **Please note that failure to return this form or to return it unsigned implies consent.**

MEMBER'S SIGNATURE (required)	DATE
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AFBS is committed to protecting the confidentiality of the personal information we collect from you. We will use this information to revise your insurance benefits as indicated by you, and to assess the eligibility of Extended Health Care and dental claims submitted by you on behalf of your dependants under the Writers' Coalition Insurance Program.

Please Send Your Completed Form To:
Actra Fraternal Benefit Society, 1000 Yonge Street, Toronto, ON M4W 2K2

