



Application to add Dependents to Same Coverage Dates as the International Student
Ref: IFAM



IMED Student's Last Name(s):	
IMED Student's First Name(s):	
Date of Birth (mm/dd/yyyy):	Student #:
Email: (required to send confirmation of coverage)	Daytime Phone #:

Note: Student information is gathered for reference only. Coverage purchased is for dependents named below only.

Coverage Dates: By using this enrolment form, you are applying to have your Eligible Dependents named below covered for the same Coverage Dates as you have on the iMED Plan. See the table below for the Coverage Dates assigned to each study program type. In order for your Dependents to have the same Coverage Dates as you, we (DCIS) must receive your application and payment within 15 days of the date your Dependents arrive in Canada. If we (DCIS) receive your application and payment more than 15 days after the date your Dependents arrive in Canada we will contact you to confirm the Coverage Dates and any necessary adjustments to the premium. In this case the earliest Coverage Start Date would be the date we receive your application and payment.

Study Program Type	Coverage Dates	Cost for 1 Dependent	Cost for 2 or more Dependents
Degree Program Start Winter Term 1	Aug. 1 st 2010– Oct. 31 st 2010	\$120	\$180
Degree Program Start Winter Term 2	Dec. 1 st 2010 – Feb. 28 th 2011	\$120	\$180
Exchange Winter Term 1 only	Aug. 30 th 2010 – Jan 5 th , 2011	\$170	\$255
Exchange Winter Term 2 only	Dec. 27 th 2010 – May 2 nd 2011	\$170	\$255
Exchange Winter Terms 1+2	Aug. 1 st , 2010 – Oct. 31 st 2010	\$120	\$180

Application from (name of student): _____

Dependant Information: Home Country of Dependents is:				
	Last Name(s):	First Name(s):	Gender	Birthdate (mm/dd/yyyy):
1.				
2.				
3.				
4.				
5.				

Date Dependents arrive in Canada (mm/dd/yy)	Date Dependents arrive in BC (mm/dd/yyyy)
Method of Payment: Credit Card Payment required for faxed orders.	
<input type="checkbox"/> Cash (Do not mail) <input type="checkbox"/> Cheque / Money Order (Payable to David Cummings Insurance Services Ltd) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	
Card Number:	Expiry Date (mm/yy):
Cardholder Name:	
<p>I certify that the above information is true and hereby apply for coverage for the Eligible Dependents named on this application. I understand the policy has limitations and exclusions and that it is my responsibility to read the policy wording. I hereby authorize release of any information, including medical records, that is needed to process a claim filed under this policy, in conjunction with the purchase of this policy, to Norfolk Mobility Benefits Inc. or its representative. I understand that the coverage will be effective on the date my Eligible Dependents arrive in Canada provided I register within 15 days of that date, otherwise coverage will be effective on the date this application is accepted by the Insurer, or its authorized agent, David Cummings Insurance Services Ltd..</p>	
Signature:	Date (mm/dd/yyyy):

<p>FAX APPLICATION TO: 604-228-9807 Mail to / Visit in person at: David Cummings Insurance Serv. Suite 350 – 2083 Alma St. Vancouver BC V6R4N6 CANADA</p>	<p>For more information, please contact us: David Cummings Insurance Services Ltd. Tel: 604-228-8816 Toll Free: 1-800-818-3188 Email: info@david-cummings.com</p>
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