



Custom Order for a Student's Spouse and/or Dependent Children



IMED Student's Last Name(s):

IMED Student's First Name(s):

Date of Birth (mm/dd/yyyy):	Student #:
-----------------------------	------------

Email Address (required to send confirmation of insurance):	Daytime Phone #:
---	------------------

Canadian Mailing Address:

City:	Province:	Postal Code:
-------	-----------	--------------

Important Notes:

- 1) Student information gathered above is for reference only so that we may confirm that your dependents are eligible for coverage and so that we can match their record with yours. Coverage purchased using this application is for your dependents named below only.
- 2) You may only purchase IMED coverage for your dependents if you (the student):
 - a) are (or have been) insured under the same IMED Group Policy GFRW1062. and
 - b) are registered as a student at UBC during the dates your dependents are covered.
- 3) You will be notified if we determine that your dependents are not eligible for IMED coverage and if so we will inform you of other health insurance options available to your dependents.

Coverage will be made effective from the date your dependents arrive in Canada if we receive this application either before they arrive in Canada, or within 15 days of their arrival in Canada. Otherwise coverage will begin on the date your application and payment are accepted by the Insurer or its authorized agent, David Cummings Insurance Services Ltd.

Dependents' arrival date in Canada (mm/dd/yyyy):	Dependents' arrival date in BC (if different to the arrival date in Canada) (mm/dd/yyyy)
---	---

Select the number of months you want your Dependents to have coverage. Rates are per dependant if there are 2 named. For 3 or more dependants, cost is 2.5 x the individual rate.

<input type="checkbox"/> 1 Month: \$40 <input type="checkbox"/> 2 Months: \$80 <input type="checkbox"/> 3 Months: \$120 <input type="checkbox"/> 4 Months: \$160	<input type="checkbox"/> 5 Months: \$200 <input type="checkbox"/> 6 Months: \$240	If you wish to purchase more than 6 months coverage please write to: info@ david-cummings.com	<u>Total Premium:</u> \$
---	--	--	--

Dependent Information

	<u>Last Name(s):</u>	<u>First Name(s):</u>	<u>Birthdate</u> <u>(mm/dd/yyyy):</u>	<u>Gender</u>
1.				
2.				
3.				
4.				
5.				
6.				

The Home Country of your dependents is:

Method of Payment: A Credit Card payment is required for faxed applications.

Cash (Do not mail) Cheque / Money Order (Payable to David Cummings Insurance Services Ltd)
 Visa MasterCard (Amex not accepted)

Card Number:

Expiry Date (mm/yyyy):

Cardholder Name:

I certify that the above information is true and hereby apply for coverage under Master Policy GFRW1062 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.

Application Date (mm/dd/yyyy):

Signature:

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

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