



Application to extend coverage or start a new policy.



① Personal Information:

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 #:	
Canadian Mailing Address:				
City:		Province:		Postal Code:
<p>Your eligibility for an extension is determined by where you will be, and what your status will be during the extension period. The same factors will determine the length of extension that you are eligible for. An insurance agent from DCIS will contact you if you are not eligible for the number of months that you are applying for. To qualify for an <u>extension</u> of coverage you must submit this application with your payment to DCIS on or before the expiry date of your most recent iMED policy. Otherwise, your application will be processed as a <u>new order</u> and if approved, your new policy will be effective on the date we receive your application and payment.</p>				
<p>During the extension period I will: (please check all that apply)</p> <p><input type="checkbox"/> continue as a registered student at UBC.</p> <p><input type="checkbox"/> be a registered student at a new school.</p> <p>Name of School: _____</p> <p><input type="checkbox"/> take an employment position at UBC.</p> <p><input type="checkbox"/> be a visitor in BC until I return to my home country.</p> <p><input type="checkbox"/> will travel in Canada until I return to my home country.</p> <p><input type="checkbox"/> will travel outside Canada until I return to my home country.</p> <p><input type="checkbox"/> remain in Canada to apply for permanent resident status or for a work permit for employment other than at UBC.</p> <p><input type="checkbox"/> other (please specify):</p>				
Where will you be during the extension period you are applying for?			Date that you will return to your home country (mm/dd/yyyy):	
My most recent iMED policy will expire on (mm/dd/yyyy):				
The cost of \$40 per month is per person if there are 2 people including the student are to be insured. For 3 or more people, the cost is 2.5 x the individual rate.				
# of coverage months	X \$40 per month	Individual Premium	X 2 for couple rate X 2.5 for family rate	\$ _____ Family Premium

② Dependent Information:

List your Dependent(s) who need coverage with you					
	Last Name(s)	First Name(s)	Date of Birth:	Relationship:	Gender
1					<input type="checkbox"/> Male <input type="checkbox"/> Female
2					<input type="checkbox"/> Male <input type="checkbox"/> Female
3					<input type="checkbox"/> Male <input type="checkbox"/> Female

③ Payment information:

Method of Payment: A Credit Card payment is required for faxed applications.	
<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 No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Expiry Date (mm/yy):
Cardholder Name:	

④ Declaration and Authorization

I certify that the above information is true and hereby apply for coverage. 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, which are needed to process a claim filed under this policy, in conjunction with the purchase of this policy, to MSH International (Canada) Ltd. or its representative. I understand that the coverage will be effective on the date I arrive in Canada if I apply in advance of, or on that date. Otherwise I understand that 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: _____

<p>FAX APPLICATION TO: 604-228-9807</p> <p>Mail your application to: David Cummings Insurance Services Suite 350 – 2083 Alma St. Vancouver, BC V6R 4N6 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 www.david-cummings.com/imed</p>
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