

Application to extend or reinstate coverage. (UBC)

Student's LAST Name(s):			
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:
<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.</p>			
<p>During the extension period I will: (check all that apply)</p> <p><input type="checkbox"/> will be waiting for coverage on the BC Medical Services Plan (MSP)</p> <p><input type="checkbox"/> be a registered student at : Name of School: _____</p> <p><input type="checkbox"/> take an employment position as a faculty or staff member at U.B.C.</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 Regent College or 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:	
Date that your current / last Global Campus Health Plan policy expires / expired			
:			

Month	/	Day	Year
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			
_____	X \$40 per month	_____	X 2.5 (family rate)
# of coverage months		Individual Premium	only if applicable
			\$ _____
			Family Premium

Applicant Name: : _____

List your Dependent(s) who need coverage with you.				
	Last Name(s):	First Name(s):	Birthdate (mm/dd/yyyy):	Sex
1.				
2.				
3.				
4.				
5.				
6.				

I certify that the above information is true and hereby apply for coverage under Master Policy GFRW1062. 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 The Norfolk International Group Inc. 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:

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

Card Number:

Expiry Date (mm/yyyy):

Cardholder Name:

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

