

FAMILY AND OPT-IN APPLICATION 2019-2020

This form will enable you to opt in your family for health benefits or opt yourself in for health benefits if this fee has not already been assessed in your tuition costs for the current school year. Please fill in the corresponding application sections below.

For more information visit: www.wespeakstudent.com

STUDENT INFORMATION • PLEASE PRINT CLEARLY:					
SURNAME		FIRST NAME		STUDENT ID	
DATE OF BIRTH Y: M: D:	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	PHONE NUMBER		DATE	
HOME MAILING ADDRESS		CITY		POSTAL CODE	
NAME OF PROGRAM			CAMPUS		

OPT-IN DEADLINE:
FALL REGISTRATION – September 30, 2019 WINTER REGISTRATION – January 31, 2020 SPRING REGISTRATION – May 31, 2020

FAMILY OPT-IN • PLEASE ENROLL THE FOLLOWING MEMBERS OF MY FAMILY

*To be eligible, all dependants must have current OHIP or equivalent coverage.
 I understand this coverage terminates at the end of the school year for which I am registered or date of withdrawal, whichever is earlier.

SURNAME	FIRST NAME	DATE OF BIRTH Y: M: D:	RELATIONSHIP TO STUDENT
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I wish to apply Health & Dental Benefits for: (indicate by checkmark)

Single Dependent	<input type="checkbox"/>	\$475.76 Fall (taxes included)	<input type="checkbox"/>	\$390.50 Winter (taxes included)	<input type="checkbox"/>	\$305.25 Spring (taxes included)
Two Dependents	<input type="checkbox"/>	\$938.66 Fall (taxes included)	<input type="checkbox"/>	\$769.10 Winter (taxes included)	<input type="checkbox"/>	\$599.55 Spring (taxes included)
Three Dependents	<input type="checkbox"/>	\$1,401.56 Fall (taxes included)	<input type="checkbox"/>	\$1,147.71 Winter (taxes included)	<input type="checkbox"/>	\$893.85 Spring (taxes included)
Four or more Dependents	<input type="checkbox"/>	\$1,864.47 Fall (taxes included)	<input type="checkbox"/>	\$1,526.31 Winter (taxes included)	<input type="checkbox"/>	\$1,188.15 Spring (taxes included)

I wish to apply for The St. Clair College Student Health & Dental Plan for the dependants registered above and agree to be bound by the benefit plan terms and conditions.
PLEASE SEND CERTIFIED CHEQUE OR MONEY ORDER TO: ACL Student Benefits, 1 Yonge Street, Suite 2000, Toronto, ON, M5E 1E5

SIGNATURE OF STUDENT	DATE
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OPT-IN • PLEASE ENROLL ME IN THE FOLLOWING * TO BE ELIGIBLE, YOU MUST HAVE CURRENT OHIP OR EQUIVALENT COVERAGE.

I wish to apply for: (indicate by checkmark)

\$300.00 Health & Dental Benefits (September Rate)
 \$233.15 Health & Dental Benefits (January Rate)
 \$166.86 Health & Dental Benefits (May Rate)

I wish to apply for The St. Clair College Student Health Plan and agree to be bound by the benefit plan terms and conditions.
PLEASE SEND CERTIFIED CHEQUE OR MONEY ORDER TO: ACL Student Benefits, 1 Yonge Street, Suite 2000, Toronto, ON, M5E 1E5

SIGNATURE OF STUDENT	DATE
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OFFICE USE ONLY

C/C	M/O	OTHER	AMOUNT	DATE RECEIVED	NSP
STUDENT FOLLOW UP				ELIGIBILITY STATUS A <input type="checkbox"/> T <input type="checkbox"/>	SEMESTER F <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/>