ALBERTA BLUE CROSS®

**INDIVIDUAL PLANS**
**OVERAGE DEPENDENT DECLARATION**
**(Please print and answer all questions in ink.)**

## A. Subscriber Information

| Applicant's Last Name | First Name | Group Number | Section | Identification Number |
|---|---|---|---|---|
| | | | | |
| Dependent's Last Name | First Name | Date of Birth (YYYY/MM/DD) | | |
| | | | | |

I declare that the above named dependent as defined in the Individual Health and Dental Plan agreement is (Check appropriate box and enter dates as required)

1. Unmarried dependent, less that twenty-six (26) years of age, in full-time attendance at an accredited educational institute and who is listed under the Members Alberta Health Care Insurance Plan coverage.

Name of educational institute: _____
Start of school term: _____
End of school term: _____

2. Unmarried dependent, twenty-one (21) years of age or older, who is financially dependent upon the Member because of infirmity, either physical or mental and who is listed under the Members Alberta Health Care Insurance Plan coverage.

(NOTE an annual Dependency Declaration is required for each school year)

I understand and agree that it is my responsibility to advise Alberta Blue Cross immediately should the dependent named cease to be eligible.

Policyholder signature _____ Date _____

 