

CONFIRMATION OF SCHOOL ATTENDANCE



Use this form to apply for group benefit coverage for over age dependent children who are full-time students.
Send the completed form to CINUP at the address below.

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Employer Name <u>ABC COMPANY</u>	
Employee Name <u>BOBBY SMITH</u>	Certificate # <u>1234</u>

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Dependents Name	Name and location of educational institution attended on a full-time basis	School Year	
		Start (MM/YYYY)	End (MM/YYYY)
<u>JANE SMITH</u>	<u>UNIVERSITY OF MANITOBA, WPG. MB</u>	<u>09/2011</u>	<u>04/2012</u>
		/	/
		/	/

Children may be covered up to their 26th birthday if they are unmarried full-time students and wholly dependent on the Employee for support. Confirmation must be forwarded to MGI Financial Inc. each year for dependents over the age of 21 and under the age of 26 in order to be eligible for coverage.

Please note that full-time students attending school outside of Canada are not eligible for the Travel Health Benefits and the International Travel Assistance coverage.

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- 1) Is the over age dependent(s) wholly dependent upon you? No Yes
- 2) Is the dependent in full-time attendance at an accredited school? No Yes If Yes, # of hours per week 20
- If so, what is the name, address and location of the school? _____

Expected date of graduation APRIL, 2014

If the student plans to return to school on a full time basis after this date, please indicate:

a) Date _____ b) Name & Location of School _____

Authorization and Consent

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by MGI Financial Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and service to me and my employer, and to manage the organization's business

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand that the personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. (For additional information regarding MGI Financial Inc.'s Group Benefits privacy policy I can contact MGI Financial at 204-786-0324 or privacy@mgiwealth.com should I have questions as to the collection, use or disclosure of my personal information)

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I certify that all information contained herein is correct. If applying for coverage for my dependents, I confirm that I am authorized to act on their behalf

Employee Signature: B. Smith Date: Sept 15/2011

Employer Signature: J. Doe Date: Sept 15/2011