Opt-in Form

Fall Semester: _____ Winter Semester: _____

Student Information

All information is mandatory:

First name: _____ Last name: _____

Student ID Number: _____ Date of Birth (YYYY/MM/DD): _____/____/____

School issued email _____

Phone Number: _____

Opt-in request:

Opt-in to the Health Plan: ___Yes ___No Opt-in to the Dental Plan: ___Yes ___No

When opting in to the plan: you must submit this form to the SU Office, and pay the applicable fees. You must complete this process by the applicable deadline. To see applicable fees, visit **studentbenefits.ca**.

Authorization

- I hereby confirm that the information contained in this form is true and complete to the best of my knowledge.
- I understand that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.
- I acknowledge my request to opt-in to my Health and/or Dental Plan for the duration of my current eligibility period is dependent upon my participation in the Plan(s). I acknowledge the request must be completed annually.

Signature: _____ Date: _____

Submit this form to the CBUSU in office or via email: dawn_macdougall@cbu.ca