Application to extend coverage (PM8686125)

Ref: EXT

David Cummings Insurance Services

① Personal Information:	
IMED Student's Last Name(s):	
IMED Student's First Name(s):	
Date of Birth (mm/dd/yyyy):	Student #:
Email: (required to send confirmation of coverage)	Daytime Phone #:
Canadian Mailing Address:	
City: Province:	Postal Code:

Eligibility for an extension is determined in part by the date your original iMED policy expires, your location, UBC student status, and occupation during the extension period requested. The same factors will determine the duration of extension that you are eligible for up to a **maximum** of 3 months. An insurance agent from DCIS will advise if you are eligible for the extension that you are applying for. For your extension application to be considered it must be r**eceived by David Cummings Insurance Services Ltd. prior to the expiration of your current iMED policy**, ***and NOTE*****the latest possible effective date for an iMED Coverage Extension is August 31, 2026**.*

During the extension period I will: (please check all that apply)

- ☐ continue as a registered student at UBC.
- ☐ be a registered student at a new school.

Name of School:

- ☐ take an employment position at UBC.
- ☐ be a visitor in BC until I return to my home country.
- ☐ will travel in Canada until I return to my home country.
- ☐ will travel outside Canada until I return to my home country.
- ☐ remain in Canada to apply for permanent resident status or for a work permit for employment other than at UBC.
- ☐ Other (please specify):

Where will you be during the extension period you are applying for?	Date that you will return to your home country (mm/dd/yyyy)

My most recent iMED policy will expire on (mm/dd/yyyy):

The cost of **$82 Canadian Dollars per month is per insured person,** for up to two people including the student are to be insured. For 3 or more people, the cost is 2.5 x the individual rate.

0 # of coverage months	X **$82** per month	$ 0.00 Individual Premium	X 2 for couple rate X 2.5 for family rate	$ Family Premium

② Dependent Information:

List your Dependent(s) who need coverage with you				
	Last Name(s)	First Name(s)	Date of Birth: (mm/dd/yyyy)	Relationship
1.				
2.				
3.				

③Payment information:

Method of Payment:
○ Interac e-Transfer* *A DCIS representative will contact you with transfer instructions ○Credit Card (Visa, MasterCard, or American Express)
If you select payment by Credit Card, DCIS will email a MONERIS Payment Request with link to the online payment form

④Declaration and Authorization

I certify that the above information is true and hereby apply for coverage. 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, which are needed to process a claim filed under this policy, in conjunction with the purchase of this policy, to MSH International (Canada) Ltd. or its representative.

I understand that this application is subject to approval by the insurer, or its authorized agent, according to the terms and conditions of the policy, including terms and conditions of eligibility.

Application Date (mm/dd/yyyy): Signature:

Email application to DCIS:	For more information, please contact us:
Email: iMedForm@david-cummings.com	Tel: 604-228-8816 Toll Free: 1-800-818-3188 Fax: 604-228-9807 Email: iMed@david-cummings.com ***Please note that service in person at our office is by appointment only.*** **www.david-cummings.com/iMED**