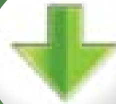
How to submit **PROOF OF COVERAGE**



INFORMATION REQUIRED

Your document must clearly indicate your coverage for extended health and/or dental care, the insurance company name, and the policy number. Your proof of coverage should relate to the portion of the plan that you want to opt out of.

ACCEPTABLE DOCUMENTS

- **An image** of a summary of benefits from an insurance company website
- **A copy** of a **certificate or card**
- **A letter** from the plan sponsor (usually the employer) or the insurance company
- Aboriginal students who receive benefits from Health Canada may provide a copy of their status card.

IT'S EASY TO SUBMIT YOUR DOCUMENTS

ELECTRONIC DOCUMENTS
(from a company's website)

1. You can use the print screen button to **capture an image** of your screen
2. **Copy, paste**, and save it in a **Word** document, as a **PDF**, or an **image file**, such as a tiff, gif, jpeg, or png.

PRINTED DOCUMENTS

1. **Scan** your letter/card OR **take a picture** with a digital camera or smart phone.
2. Save it in **PDF** format, **Word**, or as an **image file**.

PROOF OF COVERAGE EXAMPLES

WEB IMAGE Example

BENEFITS SUMMARY FROM A COMPANY'S WEBSITE

Date: **00/00/0000**
Participant: **Your Full Name**
Policy number: **00000000**
Coverage Summary: **Health and/or Dental Coverage**

YOUR INSURANCE COMPANY

YOUR COMPANY

Labels: NAME OF INSURANCE COMPANY/ LOGO; NAME OF EMPLOYER/ LOGO; HEALTH AND/OR DENTAL COVERAGE; YOUR NAME; YOUR POLICY NUMBER

OR

CARD Example

YOUR INSURANCE COMPANY

Health and/or Dental Plan

Policy 0000000

Your Full Name **Date of Birth**

Labels: NAME OF INSURANCE COMPANY; YOUR POLICY NUMBER; YOUR NAME; HEALTH AND/OR DENTAL COVERAGE

OR

LETTER Example

YOUR COMPANY LETTERHEAD

The Date

Re: **Your Full Name**

To Whom it May Concern:

This letter serves as confirmation that **your name** has extended **health and/or dental coverage** as an employee of **the place where you work**. Our benefits provider is the **name of your insurance company** and our policy number is **your insurance policy number**.

Yours truly,

Signature of Benefits Administrator

Your Benefits Administrator
Their Department
(Phone Number + Extension)

Labels: YOUR NAME; NAME OF EMPLOYER; YOUR POLICY NUMBER; CONTACT INFORMATION; HEALTH AND/OR DENTAL COVERAGE; NAME OF INSURANCE COMPANY