

CONTACTS

Please direct you **original receipts**, appropriate declaration, queries, and comments as follows:

Retirees of Laurentian University

Chantal Cayen in the Human Resources Office at (705) 675-1151, extension 3029, e-mail at cd_cayen@laurentian.ca or fax number (705) 673-6507

Retirees of Huntington University

Judy Leore at (705) 673-4126, extension 202 or email at jleore@laurentian.ca

Retirees of Thorneloe University

Mary Cornthwaite at (705) 673-1730, extension 25 or email at mcornthwaite@laurentian.ca

Retirees of University of Sudbury

Shelley Machum at (705) 673-5661, extension 318 or email at smachum@laurentian.ca

Please forward the following each year with the submission of your original receipt(s).

NOTE: If you have applied for individual medical coverage, please complete.

DECLARATION OF APPLICATION FOR INDIVIDUAL INSURANCE

I attest that I did apply for individual health coverage upon retirement for:

Self Dependents

Please provide the following information (if applicable):

Name of Spouse: _____

Date of Birth: _____

List Dependent's: _____

Date of Birth: _____

Date of Birth: _____

SIGNATURE

DATE

PLEASE PRINT NAME

COMPANY PROVIDING COVERAGE

Note: If you were unable to obtain medical coverage because of pre-existing medical condition(s) please complete.

DECLARATION OF DECLINATION FOR INDIVIDUAL INSURANCE

I attest that I did apply for individual health coverage upon retirement and that I was declined due to a pre-existing medical condition for:

- Self Spouse Dependents

I am unable to locate the letter that was forwarded to me when I was refused the health coverage.

Please provide the following information (if application):

Name of Spouse: _____ Date of Birth: _____

List Dependent's: _____ Date of Birth: _____

_____ Date of Birth: _____

SIGNATURE

DATE

PLEASE PRINT NAME

COMPANY THAT REFUSED COVERAGE

NOTE: If you did not purchase medical coverage when you retired, please complete.

DECLARATION OF NON-APPLICATION FOR INDIVIDUAL INSURANCE

I attest that I did not apply for individual health coverage upon retirement because of:

- the cost of the coverage; or
 I believed that a plan would be instituted by the employer; or
 other.

Please provide the following information (if applicable):

Name of Spouse: _____ Date of Birth: _____

List Dependent's: _____ Date of Birth: _____

_____ Date of Birth: _____

SIGNATURE

DATE

PLEASE PRINT NAME

