4 MONTH PLAN OPT-IN FORM

Date: _____

ALL FIELDS ARE REQUIRED TO BE FILLED OUT

LAST NAME: _____

FIRST NAME: _____

STUDENT #: _____

GENDER: □ **M** □ **F** **DATE OF BIRTH:** _____

DEPARTMENT: _____

SEMESTER BEING ENROLLED: □ **FALL** _____ □ **SUMMER** _____

MAILING ADDRESS: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

EMAIL ADDRESS: _____ **CELL PHONE#:** _____

□ ***I have read the 4 month policy and understand what benefits I am entitled to as posted on the GSS website. I further understand that I am eligible to opt-in to the 4 month benefits plan only ONCE as my program begins in May; as I was not assessed the fee for the GSS drug/dental benefits plan for the summer semester and must pay the GSS office IN-PERSON (Cash Only) for the 4 month plan. I do understand and agree that I will be assessed the fee for the fall semester beginning September 1 for one year. Further, I understand that by opting into the 4 month plan in May, I am not eligible to opt-in again to the 4 month plan even if I only have one semester left to complete my program.***

□ ***I have read the 4 month policy and understand what benefits I am entitled to as posted on the GSS website. I understand and agree that I am eligible to opt-in only ONCE to the 4 month plan for the Fall semester and if I am unable to successfully complete my final semester, I am not eligible to request another 4 months benefits plan and I will automatically be enrolled in January in the 8 months benefits program and NO refund will be provided. I also understand that I must provide a letter from my department/Registrar's Office by Opt-in/Opt-out deadline set by GSS to the GSS office as proof of having successfully completed my program. I understand that my refund cheque will be calculated based on the drug/dental fee of 1 year of coverage minus the cost of the 4 months benefits plan. (Example: $574.84 - $159.88 =$414.96).***

Signature: _____