APPLICATION FOR OVER-AGE DEPENDENT COVERAGE

Instructions – Please print all answers clearly.

1. Plan Member completes sections 1, 2, and 3. Physician completes section 4.
2. This form must be completed in full to avoid a delay in assessing the application. Once we have all the required information and have completed our assessment, we will notify the plan member in writing.
3. Please retain a copy of this form for your records.
4. Fees for providing medical information are the plan member's responsibility and are not covered under the plan.

Please send completed form to: Medical and Dental Claims Management
The Canada Life Assurance Company
PO Box 6000
Winnipeg, MB R3C 3A5
Fax: 204-938-2820
Email: medicalservices@canadalife.com

Questions? Call Toll Free: 1-800-957-9777 Or
Refer to your Canada Life Employee Benefits Booklet
Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511
www.canadalife.com

As email is not a secure medium, any person with concerns about their medical information being intercepted by an unauthorized party is encouraged to submit their forms by other means.

Section 1 – Plan Member Information

Plan Number	Plan Member I.D. Number	
Last Name	First Name	
Address	City and Province	Postal Code

Section 2 – Dependent Information

Last Name	First Name	
Relationship to Plan Member	Date of Birth	Marital Status ☐ Single ☐ Married/Common-Law ☐ Other: _____

Residence of Dependent

Plan Member's Home	Group Home	Hospital	Other: _____
☐ Full time ☐ Part time	☐ Full time ☐ Part time	☐ Full time ☐ Part time	☐ Full time ☐ Part time

Dependent's Education

Highest level of education attained: _____ Is the dependent currently attending an educational facility? ☐ Yes ☐ No

If "Yes": Is the dependent attending full time? ☐ Yes ☐ No Anticipated program completion date: (mm/dd/yy): _____

Name of program and facility _____

If "No": When was the last day attended _____

Note: Please attach the most recent educational assessment and/or other assessments completed in the educational setting.

Dependent's Employment

Has the dependent ever been employed? ☐ Yes ☐ No If "Yes" please provide the most recent date(s) and type(s) of employment.

Period of employment (mm/dd/yy) to (mm/dd/yy)	Employer	Job Title	Average monthly income	Hours worked per week

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Section 3 – Authorizations and Declaration

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member Signature _____ Date (mm/dd/yy) _____

Section 4 – Attending Physician's Statement

Primary Diagnosis: _____

Secondary Diagnosis: _____

Date(s) condition(s) diagnosed: _____

Functional Abilities

Does the patient have impairments in PHYSICAL functioning? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? _____

Does the patient have impairments in COGNITIVE functioning? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? _____

Please describe the nature and severity of any cognitive impairments. ***(Attach any recent cognitive assessment and/or neuropsychological report.)***

_____

_____

_____

Does the patient have impairments in any of the following areas?

Sitting	☐ Yes ☐ No	Details:
Ambulation	☐ Yes ☐ No	Details:
Lifting/Carrying	☐ Yes ☐ No	Details:
Manual dexterity	☐ Yes ☐ No	Details:
Speech	☐ Yes ☐ No	Details:
Hearing	☐ Yes ☐ No	Details:
Vision	☐ Yes ☐ No	Details:

Please indicate whether your patient requires assistance managing any of the following, and if so, describe supports needed:

Personal care/hygiene *(bathing, dressing, toileting, etc)*	☐ Yes ☐ No	Transportation *(driving, taking bus, etc.)*	☐ Yes ☐ No
Treatment *(taking medications, attending appts, etc)*	☐ Yes ☐ No	Routine/Schedule *(creating and adhering to a schedule)*	☐ Yes ☐ No
Personal finances *(banking, paying bills, budgeting, etc.)*	☐ Yes ☐ No	Decision making *(using judgement to make good decisions)*	☐ Yes ☐ No
Home care *(cooking, cleaning, grocery shopping, etc.)*	☐ Yes ☐ No	Planning *(ability to plan for the future)*	☐ Yes ☐ No

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Type(s) of supports required *(include physical supports, care supports, adaptive devices, etc)*:

Support is provided by *(include any agencies or people providing support)*:

Treatment ***(include medications, therapies, and other treatments; attach copies of recent investigations, assessments and consultations)***

Date of last appointment: _____ Date of next appointment: _____

Describe the current treatment plan (use a separate page if necessary)

List any other physicians / care providers involved in the patient's treatment (use a separate page if necessary)

Name	Specialty	Address

Prognosis: _____

Please provide any other comments you feel would assist us in understanding the patient's situation.

I declare that the information in this section is true to the best of my knowledge.

Physician's name (please print): _____ Specialty: _____

Telephone: _____ Fax: _____

Physician's address: _____

Physician's signature: _____ Date (mm/dd/yy) _____

Clear