APPLICATION FOR OVER-AGE DEPENDENT COVERAGE

Instructions

1. Plan Member completes sections 1, 2, and 3. Physician completes section 4.
2. Complete the form in full to avoid delays in assessment. Once we complete our assessment, we will write to you with our decision.
3. Please retain a copy of this form for your records.
4. Physician's fees for providing medical information are not covered under your 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
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

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 (if different from Plan Member)

Address	City and Province	Postal Code

If the dependent is not a resident of your home 365 days a year, please explain.

_____

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": Name of last program and facility attended, last day of attendance and reason for end of attendance.

_____

_____

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

Reason for leaving employment _____

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Other Coverage with Canada Life

Has the dependent ever been covered as an overage dependent under any other Canada Life plan? ☐ Yes ☐ No

If Yes, please provide the plan and ID numbers. Plan number _____ ID number _____

Plan Member's Statement

In your own words, please describe the dependent's activities on an average day. Please attach an additional page if further space is required.

_____

_____

Additional Documents

We encourage you to attach any available supporting documents from educational institutions or medical professionals. Examples include:

- **Recent educational assessments**
- **Recent cognitive assessments or neuropsychological reports**
- **Clinical notes or specialist reports issued in the past year**

Section 3 – Authorizations and Declaration

I certify that the information given on this application is true, correct and complete to the best of my knowledge.

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 application 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: _____ Date of Diagnosis _____

Secondary Diagnosis: _____ Date of Diagnosis _____

Secondary Diagnosis: _____ Date of Diagnosis _____

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.

_____

_____

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: _____

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

Please describe the type of work the patient can perform.

Treatment ***(include medications, therapies, and other treatments)***

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) _____