



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
 For the deaf or hard of hearing:
 Toll Free: 1-800-990-6654
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 <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> Other: _____		
Residence of Dependent				
Plan Member's Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Group Home <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Hospital <input type="checkbox"/> Full time <input type="checkbox"/> Part time
Other: _____ <input type="checkbox"/> Full time <input type="checkbox"/> Part time				
Dependent's Education				
Highest level of education attained: _____ Is the dependent currently attending an educational facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes": Is the dependent attending full time? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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 dental care 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Ambulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Lifting/Carrying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Manual dexterity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____

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

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

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) _____