

## 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 Questions? Call Toll Free: 1-800-957-9777 Or

The Canada Life Assurance Company PO Box 6000

Winnipeg, MB R3C 3A5

Fax: 204-938-2820

Email: medicalservices@canadalife.com

canadalife.com

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 Inform	mation					
Plan Number		Plan Member I.D. Number				
Last Name		First Name				
Address		City and Province	Postal Code			
Section 2 - Dependent Informa	tion					
Last Name		First Name				
Relationship to Plan Member Date of Birth		Marital Status  ☐ Single ☐ Married/Common-Law ☐ Other:				
Residence of Dependent (if different	nt 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 atten	ding an educational facility?    Yes    No			
If "Yes": Is the dependent a	attending full time?  Yes  No A	nticipated program completion	n 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 employees	oyed? □ Yes □ No If "Yes" pleas	e provide the most recent date	o(s) and type(s) of employment			
Period of employment	sycu. — ico — ivo ii ico picasi	o provide the most recent date	Average Hours worked			
(mm/dd/yy) to (mm/dd/yy)	Employer	Job Title	monthly income per week			
Reason for leaving employment						



Other Coverage with 0	Canada Life						
Has the dependent ever	r been covered as an over	age dependent	under any oth	ther Canada Life plan? Yes No			
If Yes, please provide the plan and ID numbers. Plan number ID number							
Plan Member's Statem	nent						
In your own words, plea	se describe the depende	nt's activities or	n an average d	day. Please attach an additional page if further space is required.			
Additional Documents							
Recent edu     Recent cog	attach any available sup ucational assessments gnitive assessments or r tes or specialist reports	neuropsycholo	gical reports	ducational institutions or medical professionals. Examples include			
Section 3 - Authoriz	ations and Declaration	n					
I certify that the inforn	nation given on this appl	ication 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.							
	ry Guidelines, or if you hav ada Life's Chief Complian			onal information policies and practices (including with respect to servic anadalife.com.			
Plan Member Signature	Date (mm/dd/yy)						
Section 4 - Attendir	ng Physician's Statem	ent					
Primary Diagnosis:				Date of Diagnosis			
Secondary Diagnosis: _				Date of Diagnosis			
Secondary Diagnosis:				Date of Diagnosis			
Functional Abilities Does the patient have in	No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A						
If the impairments are n	If the impairments are not permanent, when are they expected to resolve or improve?						
Does the patient have impairments in COGNITIVE functioning?							
If the impairments are n	If the impairments are not permanent, when are they expected to resolve or improve?						
Please describe the nat	ure and severity of any co	gnitive impairm	ents.				
Sitting	impairments in any of th						
Ambulation	Yes No	Details:					
Lifting/Carrying	☐ Yes ☐ No						
Manual dexterity	☐ Yes ☐ No						
Speech	Yes No						
Hearing	Yes No						
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 patie	Please describe the type of work the patient can perform.					
Treatment (include medications, therapies, a	and other treatments)					
	Date of last appointment: Date of next appointment:					
Describe the current treatment plan (use a						
	to the distance of the second					
List any other physicians / care providers involved in the patient's treatment						
Name Spe	ecialty	Address				
		· <del></del>				
		-				
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.						
		Specialty:				
		_ Fax:				
Physician's address:						
l <b>_</b>		Date (mm/dd/yy)				