



# 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](mailto:medicalservices@canadalife.com)  
[canadalife.com](http://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 <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> 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? <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":		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? <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
Reason for leaving employment _____			

**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](http://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	<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: _____

<b>Please indicate whether your patient requires assistance managing any of the following, and if so, describe supports needed:</b>		
Personal care/hygiene <i>(bathing, dressing, toileting, etc)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Treatment <i>(taking medications, attending appts, etc)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Personal finances <i>(banking, paying bills, budgeting, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Home care <i>(cooking, cleaning, grocery shopping, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Transportation <i>(driving, taking bus, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Routine/Schedule <i>(creating and adhering to a schedule)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Decision making <i>(using judgement to make good decisions)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Planning <i>(ability to plan for the future)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe the support needed. _____
Please describe the type of work the patient can perform. _____ _____		
<b>Treatment (include medications, therapies, and other treatments)</b>		
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
_____	_____	_____
_____	_____	_____
_____	_____	_____
<b>Prognosis:</b> _____ _____		
Please provide any other comments you feel would assist us in understanding the patient's situation. _____ _____		
<b>I declare that the information in this section is true to the best of my knowledge.</b>		
Physician's name (please print): _____ Specialty: _____		
Telephone: _____ Fax: _____		
Physician's address: _____		
Physician's signature: _____ Date (mm/dd/yy) _____		