LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

OVER-AGE DEPENDANT COVERAGE

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

OVER-AGE DEPENDANT COVERAGE

SUBMISSION INSTRUCTIONS:

- Section 1 to be completed and signed by Plan Administrator.
- Section 4 to be completed and signed by attending Physician.
- Section 2, 3 & 5 to be completed by Member.
- Include copies of supporting medical records, if required. Please keep a copy of completed application package for your records to substantiate your claim.
- Policy No. 158000.
- Send all original completed applications to:

LiUNAcare Local 183
1263 Wilson Avenue, Suite 205
Toronto, ON M3M 3G2

Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line: 1-888-790-3534
Email: info@liunacare183.com

GROUP BENEFITS
APPLICATION FOR OVER-AGE DEPENDANT COVERAGE

INSTRUCTIONS - Please print all answers

1. *Please consult your plan administrator for coverage eligibility guidelines under your plan.*
2. *Please ensure ALL SECTIONS are completed, including the section to be completed by physician.*
   - *Section 1 - To be completed first by plan administrator*
   - *Section 4 - To be completed by attending physician*
   - *Section 2, 3 & 5 - To be completed by plan member*
3. *If required, retain a photocopy for your files.*

1. Plan Sponsor Information

To be completed by plan administrator.

Plan sponsor name	Plan contract number(s)	Plan member account/division
Plan sponsor address	Plan member certificate number	Plan member name

I have reviewed the terms of over-age dependant coverage as it is outlined in our contract with Canada Life. I confirm that the undersigned plan member and dependant fit the eligibility criteria required to qualify for this coverage.

Plan administrator's signature	Date (mm/dd/yy)	Plan administrator email

2. Plan Member Information

Please complete the following:

Plan member last name	First name	Middle initial

Address	City and province	Postal code

Last name of dependant	First name

Relationship to plan member	Dependant date of birth (mm/dd/yy)

Address of dependant (if different from plan member)	City and province	Postal code

3. Disabled Dependant Information

Is the disabled dependant a resident of your home 365 days a year? ☐ Yes ☐ No

If "No", please explain.

Has the disabled dependant ever been employed? ☐ Yes ☐ No

If "Yes", please give most recent date of employment and description of type of employment.

Date (mm/dd/yyyy)	Type of employment

Is disabled dependant eligible for:
a) benefits under a government plan? ☐ Yes ☐ No
b) Health, Dental, Disability Benefits from another group plan? ☐ Yes ☐ No

If answering "Yes" to either of the above questions, please give complete details.

Are you the sole means of the disabled dependant support? ☐ Yes ☐ No

If "No", please explain.

Please confirm the dependant was covered as an Over-Age Disabled Dependent under a previous Group Insurance Plan.

Insurance company	Policy number	Certificate number	Date coverage terminated (mm/dd/yy)

M7450(158000)-12/20

4. Attending Physician

Physician - Last name	First name	Middle initial
Physician address	City and Province	Postal code
Telephone number	Fax number	Email address

1. What is the clinical diagnosis, the nature and degree of mental/physical handicap? Please provide details:

2. When was the above condition diagnosed? (mm/dd/yy) _____

3. When was the patient last examined? (mm/dd/yy) _____

4. How does the mental or physical handicap restrict the individual's ability to engage in normal activities?

5. What type of work can the individual perform?

6. Please confirm the dates this patient has been unable to work or attend school full-time due to the disability.

7. What is the prognosis?

8. Are there any additional remarks or observations you can provide?

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

Physician signature _____ Date (mm/dd/yy) _____

5. Authorizations and Declarations

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

Please sign and date here.

Plan member's signature _____ Date (mm/dd/yy) _____

6. Mailing Instructions

Please send the completed form to:

LiUNAcare LOCAL 183
205-1263 Wilson Avenue
North York, ON M3M 3G2

If you have any questions, please call 416.240.7487.