LiUNA!care

LOCAL 183 ™

BUILDING HEALTHY FUTURES

LOCAL 183 MEMBERS' BENEFIT FUND
APPLICATION FOR CHILD DISABILITY BENEFIT

LiUNA! care LOCAL 183
BUILDING HEALTHY FUTURES

200 Labourers Way, Suite 2100 | Vaughan, ON | L4H 5H9
Tel: 416-240-7487 | Toll Free: 1-888-790-3534
Email: info@liuncare183.com | liunacare183.com

Child Disability Benefit

The Child Disability Benefit is intended to assist covered members with caregiving and other expenses related to a dependent child's disability. If your dependent child is diagnosed with a condition, disease, disorder, or injury which leads to significant disability while covered, you may be entitled to the Child Disability Benefit.

What are the eligibility requirements for the Child Disability Benefit?

- A dependent child must be diagnosed with a condition, disease, disorder, or injury which leads to significant disability while the member is covered under the Local 183 Members Benefit Fund or the Local 183 Retiree Benefit Fund.
- A dependent child

  - is a natural or legally adopted child, stepchild, or other child who is dependent upon the member for support, and
  - lives with the member in a regular parent/child relationship, and
  - has a principal residence in any province or territory in Canada, and
  - is unmarried and not employed at a regular full-time job, and
  - is twenty (20) years of age or younger - children twenty-one (21) years of age but under twenty-five (25) will be covered provided they are attending an accredited school, college or university as a full-time student - proof of student registration (original) must be provided to the administrative agent.
- The Child Disability Benefit's effective date of coverage is November 1, 2024.
- The dependent child's diagnosis must be made on or after the benefit's effective date of coverage of November 1, 2024, to be eligible for this benefit.
- Any disabilities caused by conditions, diseases, disorders, or injuries diagnosed prior to the coverage start date are not eligible. This includes any conditions caused by or resulting from any conditions diagnosed or known prior to November 1, 2024.

How do I qualify for the Child Disability Benefit?

- The Child Disability Benefit pays up to a lifetime maximum of $50,000 per child and up to a $100,000 family lifetime maximum.
- In order to qualify for the Child Disability Benefit, one or more of the following criteria must be met:

(1) Listed Condition
The dependent child is diagnosed with one or more of the over one hundred fifty (150) Listed Conditions specified by name. The full list can be found at the end of this document.
(2) Long-term Hospitalization
The dependent child is hospitalized for a continuous period of thirty (30) overnight stays or more.
(3) Severe Medical Complexity or Disability
The dependent child has a high degree of medical complexity or caregiving needs, or severe functional limitations in mobility, activities of daily living, or social and cognitive function compared to children of the same age that has lasted, or is expected to last, a continuous period of at least ninety (90) days or is expected to result in death within ninety (90) days.

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Child Disability Benefit

How is the Child Disability Benefit amount determined?

- Each Child Disability Benefit Type is assessed and assigned a **Severity Level** score between 1 to 5 based the nature of the condition and level of disability.
- **(1) Listed Conditions** are assigned a minimum severity level. The full list is found at the end of this document. Dependent children with multiple listed conditions may be assigned either the highest minimum severity level of one of their conditions or a higher combined severity level than the individual condition minimums.
- **(2) Long-term Hospitalizations** of 30 days or more are assigned a severity level of 4.
- **(3) Severe Medical Complexity or Disability** is assessed based on the dependent child's functional abilities compared to other children of the same age across mobility, activities of daily living, and social and cognitive function, as well as for medical complexity and additional care needs. This is verified with medical and other records to determine medical complexity and additional care needs.
- The severity level score increases as caregiving and healthcare demands increase and the child's independence and ability to participate in activities of daily living decreases.

How is the Child Disability Benefit paid?

- The Child Disability Benefit amount payable is shown below by severity level and expected duration:

Severity Level	Severity Level Lifetime Maximum	Long Duration Condition (Permanent or 8+ months expected) Lump Sum	Short Duration Conditions (less than 8 months expected) Monthly Benefit
1	$10,000	$10,000	$1,250
2	$20,000	$20,000	$2,500
3	$30,000	$30,000	$3,750
4	$40,000	$40,000	$5,000
5	$50,000	$50,000	$6,250

- Long Duration Conditions (permanent conditions or conditions expected to last 8 or more months) are paid as a lump-sum at the severity level maximum.
- Short Duration Conditions (conditions expected to last less than 8 months) are paid monthly up to the severity level maximum.
- Benefits are paid directly to the member by cheque.
- The member decides how to best use the benefit for their child and family.

How to apply for the benefit?

1. Ensure the eligibility requirements for this benefit are met.
2. Complete the application in full and sign the form.
3. Return the completed application form to LiUNAcare Local 183 to

   Email: **info@liunacare183.com**

   Mail: **200 Labourers Way, Suite 2100 | Vaughan, Ontario | L4H 5H9**

If there are any questions, contact Member Services at 416-240-7487 or toll-free at 1-888-790-3534 or email us at info@liunacare183.com.

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CHILD DISABILITY BENEFIT

Application Form

Part I - MEMBER STATEMENT

Member Information		
First Name	Last Name	
Union ID	Date of Birth (YYYY-MM-DD)	Telephone Number
Email Address		Alternate Number
Member Principal Residence		
Address		Town/City
Province	Postal Code	Country
Member Mailing Address (if different than above)		
Address		Town/City
Province	Postal Code	Country

What is your relationship with the child you are claiming benefits for?

- ◯ Biological parent
- ◯ Stepparent, since _____ (YYYY-MM-DD)
- ◯ Adoptive parent, since _____ (YYYY-MM-DD)
- ◯ Other, since _____ (YYYY-MM-DD)

Please describe: _____

Is your child dependent on you for support, unmarried, and not employed at a regular full-time job?

◯ Yes ◯ No

If no, please explain: _____

For a child aged 21 to 25, are they attending an accredited school, college or university as a full-time student?

◯ Yes ◯ No

If yes, please provide proof of student registration with your submitted claim form.

Part II – CHILD INFORMATION

Child Information		
First Name	Last Name	
Date of Birth (YYYY-MM-DD)	Telephone Number *	Alternate Number *
Email Address *		
Principal Residence (if different than Member)		
Address		Town/City
Province	Postal Code	Country

*Please include if your child is older than eighteen (18) and has legal capacity.

Long-Term Child Disability Benefits:

Please use your best judgment to indicate the benefits you would like to claim below (check all that apply). If you are uncertain about the benefits your child may qualify for, please contact LiUNAcare Local 183.

☐ **Long-term Hospitalization** is hospitalization for a continuous period of thirty (30) or more overnight stays that begins while coverage is in effect.

☐ **Listed Condition** is a diagnosis of one or more covered conditions.

☐ **Severe Medical Complexity or Disability** is a high degree of medical complexity or caregiving needs, or severe functional limitations in mobility, activities of daily living, or social and cognitive function, as compared to children of the same age that have lasted, or are expected to last, for a continuous period of at least ninety (90) days, or are expected to result in death within ninety (90) days.

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CONDITION INFORMATION SECTION

Please complete this section to provide information about your child's condition(s).

Please describe your child's condition(s), including any illness, disability, functional limitation, and diagnosed condition(s) if known.
When did you first notice your child's condition(s)? If caused by an accident or injury, on what date did it occur? If your child has any diagnosed condition(s), please write each condition and date of diagnosis. (YYYY-MM-DD)
When was your child first seen or treated by a medical professional for your child's illness, disability, or functional limitation?

Please use the blank page near the end of this form to provide additional information if needed.

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CARE INFORMATION SECTION

Please provide information regarding the care your child receives.

Please describe in detail the care your child receives because of their condition(s). Please include any specialized services or care provided by you or an outside service provider.

Please use the blank page near the end of this form to provide additional information if needed.

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HOSPITALIZATION SECTION

If your child was hospitalized related to this claim, please complete this section.
Otherwise, please skip this section.

Please provide details for each hospitalization relating to this claim. If your child is currently still in the hospital, please write "N/A" or "Not Applicable" for the date of discharge.	
Hospital Name	Admission Date (YYYY-MM-DD)
Hospital Address	Discharge Date (YYYY-MM-DD)
Reason for Hospitalization	
Hospital Name	Admission Date (YYYY-MM-DD)
Hospital Address	Discharge Date (YYYY-MM-DD)
Reason for Hospitalization	
Hospital Name	Admission Date (YYYY-MM-DD)
Hospital Address	Discharge Date (YYYY-MM-DD)
Reason for Hospitalization	
Hospital Name	Admission Date (YYYY-MM-DD)
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Reason for Hospitalization	
Hospital Name	Admission Date (YYYY-MM-DD)
Hospital Address	Discharge Date (YYYY-MM-DD)
Reason for Hospitalization	

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PHYSICIAN SECTION

Please provide information regarding your child's treating providers in this section.

CHILD'S PRIMARY PHYSICIAN	
Physician Name	First Date Seen (YYYY-MM-DD)
Specialty	Last Date Seen (YYYY-MM-DD)
Physician Address	Telephone & Fax Number
OTHER TREATING PHYSICIANS Please list all other physicians your child has seen related to this claim. This may include current as well as former providers.	
Physician Name	First Date Seen (YYYY-MM-DD)
Specialty	Last Date Seen (YYYY-MM-DD)
Physician Address	Telephone & Fax Number
Physician Name	First Date Seen (YYYY-MM-DD)
Specialty	Last Date Seen (YYYY-MM-DD)
Physician Address	Telephone & Fax Number
Physician Name	First Date Seen (YYYY-MM-DD)
Specialty	Last Date Seen (YYYY-MM-DD)
Physician Address	Telephone & Fax Number
Physician Name	First Date Seen (YYYY-MM-DD)
Specialty	Last Date Seen (YYYY-MM-DD)
Physician Address	Telephone & Fax Number

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EDUCATION AND SPECIALIZED SERVICES SECTION

Please provide information regarding your child's programs or services if applicable.

NAME OF CURRENT SCHOOL / EARLY CHILDHOOD PROGRAM (If applicable)	
School or Program Name	First Date of Attendance (YYYY-MM-DD)
Address	Telephone Number
Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes	If yes, please provide a copy. When was the program or plan first put in place? (YYYY-MM-DD)
SPECIALIZED SERVICES OR CARE PROVIDERS If applicable, list all current and past services and providers related to this claim.	
Provider Name	Service Start Date (YYYY-MM-DD)
Specialized Service	Service End Date (YYYY-MM-DD)
Address	Telephone Number
Email Address	Fax Number
Provider Name	Service Start Date (YYYY-MM-DD)
Specialized Service	Service End Date (YYYY-MM-DD)
Address	Telephone Number
Email Address	Fax Number
Provider Name	Service Start Date (YYYY-MM-DD)
Specialized Service	Service End Date (YYYY-MM-DD)
Address	Telephone Number
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PART III - ADMINISTRATOR CONSENT

I/We certify that the statements provided by me are true and accurate to the best of my knowledge and belief.

As a member of LiUNAcare Local 183, administered by Benefit Plan Administrators Limited (BPA) on behalf of the Local 183 Benefit Trust Funds, I hereby consent to BPA's collection, use, and disclosure of my personal information for purposes related to determining my eligibility and entitlements under the benefit plan and for the review of claim submissions. This consent includes:

• Authorization for Information Collection: I authorize any physician, health professional, healthcare provider, hospital, medical facility, or related organization to release necessary personal information, including that of my dependents, to BPA. This information will be collected solely for the purposes of assessing eligibility, determining benefit entitlements, and reviewing claim submissions under the plan.

• Disclosure to Insurance Carriers and Benefit Providers: I permit BPA to disclose and exchange my personal information, including that of my dependents, with insurance carriers, benefit providers, and relevant service partners as necessary to administer and execute the benefit plan effectively, including reviewing and processing claims.

• Commitment to Privacy and Confidentiality: BPA is committed to protecting and maintaining the confidentiality of all personal information collected. All information will be handled in accordance with applicable privacy laws and BPA's internal data protection policies, ensuring secure handling and storage.

• Right to Withdraw Consent: I understand that I may withdraw this authorization at any time by providing written notice to BPA. I also confirm that a photocopy or electronic copy of this authorization shall be considered as valid as the original.

By signing below, I consent to BPA's collection, use, and disclosure of my personal information as outlined above, acknowledging that withholding or withdrawing this consent may impact the processing or approval of my insurance claims.

Member's Name	
Member's Signature	Date (YYYY-MM-DD)

Please complete the following if your child is older than eighteen (18) and has legal capacity.

Child's Name	
Child's Signature	Date (YYYY-MM-DD)

Please submit your completed claim form to LiUNAcare Local 183.

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PART III - INSURER CONSENT

I/We understand that Trisura Guarantee Insurance Company ("Trisura") may investigate or review this claim. I/We authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, Workers' Compensation Board, group plan administrator, employer, policyholder or any other corporation, organization, institution, association or person to release and exchange any medical or benefit payment information or any other records requested by Trisura to establish or review the validity of this claim.

Use and Disclosure

Information obtained by use of the Authorization will be used to determine eligibility for benefits under an insurance policy. Any information obtained will not be released, to any person or organization except to medical professionals who I/We or Trisura have asked to assess my medical condition, reinsuring companies, third party administrators, claim consultants or other persons or organizations performing business or legal services in connection with this claim or as may be otherwise lawfully required or as I/We may further authorize.

I/We understand that this information will be maintained in a group life, health, or disability file with Trisura. I/We understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information.

I/We authorize the use of my social insurance number for the purpose of tax reporting and for the identification and administration of the group benefits.

I/We agree that a photocopy of this authorization shall be as valid as the original.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Member's Name	
Member's Signature	Date (YYYY-MM-DD)

Please complete the following if your child is older than eighteen (18) and has legal capacity.

Child's Name	
Child's Signature	Date (YYYY-MM-DD)

Please submit your completed claim form to LiUNAcare Local 183.

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PART IV - PRIVACY POLICY

Consent

Canada's privacy laws stipulate that an individual's consent is required prior to or at the time we collect his or her personal information. Consent is also required prior to disclosing any personal information to a third party, except in certain situations identified in the legislation. Consent may be written, oral or implied when an individual requests product from Trisura and provides personal information, when an existing client requests further products or policy renewals, or when a client continues to use our products or services without objection after receipt of this Privacy Policy. Please note that if an individual refuses consent to the collection, use or disclosure of his or her personal information then Trisura may be unable to provide the product or service requested.

Disclosure of Personal Information

From time to time in the normal course of business, it is necessary for Trisura to provide an individual's personal information to a third party such as, but not limited to, a broker, reinsurer, legal counsel, regulator, adjustor, repairer, or administrator. Trisura advises each third party to whom it provides personal information that Trisura expects the party to comply with Canada's privacy laws and to also take steps to protect that information. Information on third parties is available from the Chief Privacy Officer. We will only disclose an individual's personal information with the individual's consent, except in situations where to do so would cause undue delay in providing requested services or where Trisura is legally required to disclose such information.

Retention of Personal Information

Trisura will retain an individual's personal information for as long as is necessary to fulfill the purposes for which it was collected or as required by law. Disposal of any personal information no longer required will be done in a safe and complete manner.

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PART V - ADMINISTRATOR AUTHORIZATION

Member Coverage Effective Date _____ (YYYY-MM-DD)

Member Status on Date of Occurrence of Claim

☐ Current Insured Member In Benefit
☐ Current Insured Retiree In Benefit
☐ Other (please explain): _____

ADMINISTRATOR SIGNATURE

A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing false, incomplete or misleading information, commits a fraudulent Insurance Act, which is a crime.

Name of Authorized Personnel (please print)	Date (YYYY-MM-DD)
Title of Authorized Personnel	Telephone Number
Signature of Authorized Personnel	Email Address

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