LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

# OVER-AGE DEPENDANT COVERAGE

# LiUNA LOCAL 183
# MEMBERS BENEFIT FUND

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## 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**
2100 - 200 Labourers Way
Vaughan, ON L4H 5H9

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

# Group Benefits Application for Dependant with a Disability 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, 6 & 7 - 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) |
|---|---|---|---|
| | | | |



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## 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. Privacy

**Protecting your personal information.** At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

**How we use your personal information.** Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

**Who we share personal information with.** We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

**You're in control of your personal information.** We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your online account or by submitting a request through our privacy centre at canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

**Want to learn more?** Please visit canadalife.com/privacy.

## 6. Privacy consent, authorization and signature

I understand that my personal information will be collected, used and shared as set out above.

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 dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offense. 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. I agree that by submitting this form or authorizing it to be submitted, I am consenting to the terms set out in this section, even if I have not signed the form.

Plan member signature: _____ Date: _____

## 7. Mailing Instructions

Please send the completed form to:

**LiUNAcare LOCAL 183**
**200 Labourers Way**
**Suite 2100**
**Vaughan, ON L4H 5H9**

If you have any questions, please call 416.240.7487.



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