LiUNA!care
LOCAL 183™
BUILDING HEALTHY FUTURES

Members Benefit Fund | Construction Division

CHILD DISABILITY BENEFIT

Policy Nº - JCI-941876281-01

LiUNA!care LOCAL 183
MEMBER HEALTH MANAGEMENT SERVICES

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: memberhealthservices@liunacare183.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.

Eligibility Requirements

- You must be a Member with plan coverage on the date your dependent child is diagnosed with a condition, disease, disorder, or injury which leads to significant disability.
- 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.

Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Member to complete and sign Application Form.
3. Include any supporting medical records.
4. Return the completed application to LiUNAcare Local 183 Member Health Management Services by

   Email: **memberhealthservices@liunacare183.com**
   Mail: **200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9**
   Fax: **416-240-7047**
   Questions: Email or call us at **416-240-2104** or **1-866-315-6011**

5. Keep a copy of the completed application for your records to substantiate your claim.

LiUNA!care LOCAL 183
MEMBER HEALTH MANAGEMENT SERVICES

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: memberhealthservices@liunacare183.com | liunacare183.com

Child Disability Benefit

Benefit Criteria

- 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 of the Listed Conditions 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 disability or condition(s) which results in 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.

- 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 severity level. 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) Hospitalizations** of 30 days or more are eligible for $5,000 per month up to a maximum of $50,000.
- **(3) Severe Medical Complexity or Disability** is assessed based on the dependent child's functional abilities compared. 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.

Benefit

- The Child Disability Benefit is payable based on the severity level and expected duration:

Severity Level	Severity Level Lifetime Maximum	Long Duration Condition Lump Sum	Short Duration Conditions 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.
- The Child Disability Benefit pays up to a lifetime maximum of $50,000 per child and up to a $100,000 family lifetime maximum.

Listed Conditions

Severity Level 1

Benefit Amount: $10,000

Cardiac

- Congenital Heart Disease
- Endomyocardial Fibrosis
- Fulminant Giant Cell Myocarditis
- Heart Transplant Waiting List 1B

Genetic/Syndromic

- Alexander Disease (ALX) - Juvenile or Adult Form
- Allan-Herndon-Dudley Syndrome
- Alpha Mannosidosis - Type II
- Alstrom Syndrome
- Ataxia Telangiectasia
- Cornelia de Lange Syndrome
- Creatine Transporter Deficiency
- Cri du Chat Syndrome - Ages 3 and Younger
- Cystic Fibrosis Classic Form
- Degos Disease - Stage 2 (Malignant Atrophic Papulosis)
- Down Syndrome (Trisomy 21)
- Duchenne Muscular Dystrophy
- Farber Disease Types 1, 2, or 3
- Fibrodysplasia Ossificans Progressiva
- Friedreich's Ataxia
- Frontotemporal Dementia
- Fucosidosis - Type 11
- Galactosialidosis - Late Infantile or Juvenile Type
- Gaucher Disease (GD) - Type 3
- Giant Axonal Neuropathy
- Glucose Transporter Disorder
- Glutaric Acidemia - Type 1
- Glutaric Acidemia - Type 2: Neonatal without Congenital Anomalies and Late Onset
- Hunter Syndrome
- (Mucopolysaccharidosis type II)
- Huntington Disease - Juvenile Onset
- Hurler Syndrome
- (Mucopolysaccharidosis type I)
- Hutchinson-Gilford Progeria Syndrome
- Hypocomplementemic Urticarial Vasculitis (HUV) / HUV Syndrome
- Infantile Neuroaxonal Dystrophy (INAD)
- Juvenile Amyotrophic Lateral Sclerosis (JALS)
- Lissencephaly
- Lowe Syndrome
- Major Organ Failure on Waiting List - Pancreas, Intestines, or Bone Marrow
- Metachromatic Leukodystrophy
- Myoclonic Epilepsy with Ragged Red Fibers Syndrome
- Myotonic Dystrophy - Congenital
- Neurodegeneration with Brain Iron Accumulation
- Neuronal Ceroid Lipofuscinosis - Juvenile Form (Batten Disease, CLN3 Disease)
- Neuronal Ceroid Lipofuscinosis - Non-Juvenile Forms
- Niemann-Pick Disease (NPD) - Type B
- Niemann-Pick Disease (NPD) - Type C
- Ornithine Transcarbamylase (OTC) Deficiency
- Osteogenesis Imperfecta (OI) - Type III or IV
- Pallister-Killian Syndrome
- Pearson Syndrome
- Pelizaeus-Merzbacher Disease - Classic Form
- Phelan-McDermid Syndrome
- Pyruvate Dehydrogenase Deficiency
- Rett (RTT) Syndrome - Zappella Variant
- Revesz Syndrome
- Riboflavin Transporter Deficiency Neuronopathy
- Sialic Acid Storage Disease - Salla or Intermediate Severe Salla Disease
- Spina Bifida - Myelomeningocele
- Stiff Person Syndrome
- Tay-Sachs Disease - Juvenile Onset Type
- Ullrich Congenital Muscular Dystrophy
- Xeroderma Pigmentosum

Hematologic/Immunologic

- Agammaglobulinemia or Severe Hypogammaglobulinemia
- Amegakaryocytic thrombocytopenia
- Hemophilia - Severe
- Hemophagocytic Lymphohistiocytosis

Hepatic/Gastrointestinal

- Hepatopulmonary Syndrome

Neurological/Neurodevelopmental

- Autism
- Cerebral Palsy - Level 3 (GMFCS)
- Epilepsy or Chronic Seizures - Infrequent with Loss of Consciousness
- Epilepsy or Chronic Seizures - Moderate without Loss of Consciousness

Renal

- Chronic Kidney Disease Stage 5 or End-Stage Renal Disease (ESRD)

Respiratory

- Idiopathic Pulmonary Fibrosis
- Obliterative Bronchiolitis (Bronchiolitis Obliterans, BOS)

Sensory

- Hearing Loss - Profound (Deafness)

Listed Conditions

Severity Level 2

Benefit Amount: $20,000

Genetic/Syndromic

- Aicardi-Goutieres Syndrome - Late Onset
- Alexander Disease (ALX) - Infantile Form
- Alpha Mannosidosis – Type III
- Alpha Thalassemia Major (Hemoglobin Barts)
- Angelman Syndrome
- Canavan Disease - Infantile Form
- Caudal Regression Syndrome - Type III or IV
- Coffin-Lowry Syndrome - Males
- De Sanctis Cacchione Syndrome
- Dravet Syndrome
- Fucosidosis - Type I
- Guanidinoacetate Methyltransferase Deficiency (GAMT)
- Hypophosphatasia - Infantile Onset Type
- I Cell Disease
- MECP2 Duplication Syndrome
- Menkes Disease Classic or Infantile Form
- Miller-Dieker Syndrome
- Pompe Disease - Infantile
- Rhizomelic Chondrodysplasia Punctata
- Roberts Syndrome
- Seckel Syndrome
- Sjogren-Larsson Syndrome
- Spinal Muscular Atrophy (SMA) - Type 2
- Usher Syndrome - Type I

Hematologic/Immunologic

- AIDS
- X-Linked Lymphoproliferative Disease

Neurological/Neurodevelopmental

- Amyotrophic Lateral Sclerosis (ALS)
- Cerebral Palsy - Level 4 (GMFCS)
- Epilepsy or Chronic Seizures - Moderate with Loss of Consciousness
- Paraplegia - Complete
- Subacute Sclerosing Panencephalitis

Respiratory

- End-Stage Lung Disease

Sensory

- Blindness (Permanent Loss of Eyesight)

Listed Conditions

Severity Level 3

Benefit Amount: $30,000

Cancer

- Cancer - Invasive

Genetic/Syndromic

- Biotin-Responsive Basal Ganglia Disease - Early Infantile Type
- Farber Disease Type 5
- Fukuyama Congenital Muscular Dystrophy
- Glutaric Acidemia - Type 2: Neonatal with Congenital Anomalies
- GPX4 Gene Disorder
- Leigh's Disease
- Marshall-Smith Syndrome
- Merosin Deficient Congenital Muscular Dystrophy
- Neonatal Adrenoleukodystrophy
- NFU-1 Mitochondrial Disease
- Nonketotic Hyperglycinemia - Attenuated
- Pelizaeus-Merzbacher Disease Connatal Form
- Rett (RTT) Syndrome - Classic
- Rett (RTT) Syndrome - Hanefeld Variant
- Sanfilippo Syndrome
- Wolf-Hirschhorn Syndrome

Neurological/Neurodevelopmental

- Cerebral Palsy - Level 5 (GMFCS)
- Epilepsy or Chronic Seizures - Severe with Loss of Consciousness

Listed Conditions

Severity Level 4

Benefit Amount: $40,000

Cardiac

- Heart Transplant Graft Failure
- Heart Transplant Waiting List 1A

Genetic/Syndromic

- Cerebro-Oculo-Fascio-Skeletal (COFS) Syndrome
- Creutzfeldt-Jakob Disease (CJD)
- Lesch-Nyhan Syndrome (LNS)
- Rett (RTT) Syndrome - Rolando Variant
- Schindler Disease - Type I
- Sialic Acid Storage Disease Infantile Free

Hematologic/Immunologic

- Severe Combined Immunodeficiency (SCID)
- Hepatic/Gastrointestinal
- Decompensated Cirrhosis

Neurological/Neurodevelopmental

- Epilepsy or Chronic Seizures - Daily Intractable
- Quadriplegia (Tetraplegia) - Complete

Listed Conditions

Severity Level 5

Benefit Amount: $50,000

Genetic/Syndromic

- Aicardi-Goutieres Syndrome – Early Onset
- Alexander Disease (ALX) - Neonatal Form
- Alpers Disease
- Anencephalus
- Edwards Syndrome (Trisomy 18)
- Farber Disease Type 4
- Fryns Syndrome
- Galactosialidosis - Early Infantile Type
- Gaucher Disease (GD) - Type 2
- Holoprosencephaly Alobar
- Hoyeraal-Hreidarsson Syndrome
- Hydranencephaly
- Hypophosphatasia - Perinatal Type
- Junctional Epidermolysis Bullosa - Lethal Type
- Krabbe Disease (KD) - Infantile
- Niemann-Pick Disease (NPD) - Type A
- Nonketotic Hyperglycinemia - Severe
- Ohtahara Syndrome (Early Infantile Epileptic Encephalopathy)
- Osteogenesis Imperfecta (OI) - Type II
- Patau Syndrome (Trisomy 13)
- Progressive Multifocal Leukoencephalopathy
- Sandhoff Disease - Infantile
- Spinal Muscular Atrophy (SMA) - Types 0 or 1
- Tay-Sachs Disease - Infantile Type
- Thanatophoric Dysplasia - Type 1
- Walker Warburg Syndrome
- Wolman Disease
- X-Linked Myotubular Myopathy
- Zellweger Syndrome

Renal

- Hepatorenal Syndrome

LiUNA! care LOCAL 183
BUILDING HEALTHY FUTURES

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.

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.

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.

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)
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	

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

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

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

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
Email Address	Fax Number

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

Please use this page to provide any additional information.

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.

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.

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.

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