

**LiUNA!**care

LOCAL 183 <sup>TM</sup>

BUILDING HEALTHY FUTURES

## OVER-AGE DEPENDENT COVERAGE

Industrial Division

Members Benefit Fund



Policy N° - 158000

## Over-Age Dependent Coverage

If a dependent child has reached the coverage age limitation of 21 years of age or 25 years of age if they attended an accredited school, college, or university as a full-time, plan coverage may be extended in the event of a dependent child's disability.

### Eligibility Requirements

- The dependent child must be
  - Incapable of supporting themselves due to physical or cognitive disability,
  - Become incapacitated prior to the coverage age limitation, and
  - Is chiefly dependent upon the Member for support and maintenance.
- Proof of disability must be supported by a licensed physician (M.D.) in Canada.
- Proof must be submitted to the Administrative Agent as required but not more often than yearly.

### Benefit

- Continuation of Extended Health, Vision Care, Dental Care, Emergency Out of Province Medical, and Hospital Cash benefit coverages.

### Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Plan Member to complete Parts 2, 3, and 5 of the Application for Over-Age Dependant Coverage Form.
3. Attending Physician to complete Part 4 of the Application for Over-Age Dependant Coverage Form.
4. Include any supporting medical records.
5. Return the completed application to LiUNAcare Local 183 Member Health Management Services by



Email: [memberhealthservices@liunacare183.com](mailto: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**

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

## 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.

<b>1. Plan Sponsor Information</b>  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

  

<b>2. Plan Member Information</b>	<b>Please complete the following:</b>		
	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

  

<b>3. Disabled Dependant Information</b>	Is the disabled dependant a resident of your home 365 days a year? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain.		
	_____ _____		
	Has the disabled dependant ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Health, Dental, Disability Benefits from another group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If answering "Yes" to either of the above questions, please give complete details.		
	_____ _____		
	Are you the sole means of the disabled dependant support? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

<b>4. Attending Physician</b>	Physician - Last name	First name	Middle initial
	Physician address	City and Province	Postal code
	Telephone number	Fax number	Email address
	<p>1. What is the clinical diagnosis, the nature and degree of mental/physical handicap? Please provide details:</p> <p>_____</p> <p>_____</p> <p>2. When was the above condition diagnosed? (mm/dd/yy) _____</p> <p>3. When was the patient last examined? (mm/dd/yy) _____</p> <p>4. How does the mental or physical handicap restrict the individual's ability to engage in normal activities?</p> <p>_____</p> <p>_____</p> <p>5. What type of work can the individual perform?</p> <p>_____</p> <p>_____</p> <p>6. Please confirm the dates this patient has been unable to work or attend school full-time due to the disability.</p> <p>_____</p> <p>_____</p> <p>7. What is the prognosis?</p> <p>_____</p> <p>_____</p> <p>8. Are there any additional remarks or observations you can provide?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>I DECLARE that the information in this section is true to the best of my knowledge.</b></p> <p>Physician signature _____ Date (mm/dd/yy) _____</p>		
<b>5. Authorizations and Declarations</b>	<p>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.</p> <p>I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.</p> <p>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 <a href="http://www.canadalife.com">www.canadalife.com</a></p> <p>Please sign and date here. _____</p> <p>Plan member's signature _____ Date (mm/dd/yy) _____</p>		
<b>6. Mailing Instructions</b>	<p>Please send the completed form to:</p> <p><b>LIUNAcare Local 183</b>  <b>200 Labourers Way, Suite 5400</b>  <b>Vaughan, ON. L4H 5H9</b>  <b>Email: <a href="mailto:memberhealthservices@liunacare183.com">memberhealthservices@liunacare183.com</a></b>  <b>Fax: 416-240-7047</b></p>		