Chambers Plan
Employee Benefits

JG100-CH

Application for Over-Age Disabled Dependent Coverage

Employee's Name _____ Firm # _____ Certificate # _____

Dependent's Name _____ Employee's relation to the dependent _____

Dependent's Present Age _____ Dependent's date of birth (YYYY/MM/DD) _____

1. Is the disabled dependent wholly dependent upon you? ❑ Yes ❑ No
2. Is the disabled dependent eligible for a) benefits under a government Plan? ❑ Yes ❑ No
   b) health, dental or disability benefits from another group plan? ❑ Yes ❑ No

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

   _____

   _____

3. Do you or your spouse claim this dependent as a "Disabled Dependent" for tax purposes? ❑ Yes ❑ No

   If "Yes", please provide a copy of the most recent *Disability Tax Credit Certificate* indicating the name of the disabled dependent and the duration of eligibility of the tax credit.

   If "No", you must apply to Canada Revenue Agency and forward your *Disability Tax Credit Certificate*.

Please have the dependent's attending physician complete the Physician Statement that follows.

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that the dependent child identified is totally and permanently disabled. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Chambers of Commerce Group Insurance Plan® to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy Policy on www.chamberplan.ca or from the administrator of my benefit program.

A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

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Attending Physician Statement

To be completed by the disabled dependent's attending physician. The employee assumes responsibility for any costs associated with the completion of this form.

Dependent Child's Name _____ Dependent Child's Birthdate (YYYY/MM/DD) _____

1. Onset date of disability

_____

2. Nature and degree of disability

_____

_____

_____

_____

3. Impairment or restrictions resulting from the condition

_____

_____

_____

_____

4. Is the dependent capable of working for remuneration or profit? ❑ Yes ❑ No

5. Prognosis of present condition. Is the condition permanent or can improvement be anticipated?

_____

_____

_____

_____

Physician Information

Name _____ Specialization _____

Address _____

Phone (_____) _____

Signature _____ Date _____