

## 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 over-age dependent financially 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](http://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 \_\_\_\_\_

## 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 \_\_\_\_\_