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JG100

APPLICATION FOR OVER-AGE DISABLED DEPENDENT COVERAGE

Employee's Name _____ Certificate # _____

Firm/Company Name _____ Firm/Division # _____

Dependent's Name _____ Relationship _____

Dependent's Date of Birth (YYYY/MM/DD) _____ Date disability began (YYYY/MM/DD) _____

Nature of Disability _____

1) Is your disabled dependent living with you and wholly dependent on you for support? ◯ Yes ◯ No

2) Is the disabled dependent eligible for a) benefits and/or assistance 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 Canada Revenue Agency *Disability Tax Credit Certificate* approval letter 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 a copy of your *Disability Tax Credit Certificate* approval letter when approved.

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 is totally and permanently disabled. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Maximum Benefit and its insurers 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. I authorize such collection and disclosure to be conducted by any means necessary, including electronic communication methods such as email. 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 and Terms of Use section of www.maximumbenefit.ca or from the administrator of my benefit program.

Any copy of this authorization shall be as valid as the original.

Signature of Employee _____ Date _____

MAXIMUM BENEFIT NATIONAL SERVICE CENTRE
1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1 800 893-7587

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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 _____

1) Diagnosis of dependent child's present condition

_____

_____

_____

2) When was the above condition diagnosed?

_____

3) When was the child last examined?

_____

4) Type and frequency of medication/treatment prescribed

_____

_____

_____

5) Impairment or restrictions resulting from the condition

_____

_____

_____

6) Does the dependent require assistance with activities of daily living? ◯ Yes ◯ No

If "Yes", please provide details. _____

_____

7) Is the dependent capable of working for remuneration or profit? ◯ Yes ◯ No

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

_____

_____

_____

_____

Physician Information

Name _____ Specialization _____

Address _____

Phone _____

Signature _____ Date _____