Chambers of Commerce
Group Insurance Plan®

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 and Terms of Use section of www.chambers.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 Number _____

Signature _____ Date _____