Manulife

Group Benefits
Application for Over-age Dependant Requiring Special Attention 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.**

1. Plan sponsor information

Plan sponsor name: | Plan contract number(s): | Plan member account/division:

Plan sponsor address: | Plan member certificate number: | Plan member name:

Self administered plan administrators please read and complete.

I have reviewed the terms of over-age dependant coverage as it is outlined in our contract with Manulife. **I confirm** that the undersigned plan member and dependant fit the eligibility criteria required to qualify for this coverage.

Plan administrator's signature: | Date (dd/mmm/yyyy):

Plan administrator email:

2. Plan member information

Please complete the following.

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 (dd/mmm/yyyy):

Sex*: ◯ Male ◯ Female ◯ Non-binary

* Select male, female or non-binary consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Address of dependant if different from plan member : | City and province: | Postal code:

3. Dependant information

1. Is the dependant a resident of your home 365 days a year? ◯ Yes ◯ No

If **no**, please explain.

2. Has the dependant ever been employed? ◯ Yes ◯ No

If **yes**, please give most recent date(s) of employment and description of type of employment.

Start date (dd/mmm/yyyy): | End date (dd/mmm/yyyy): | Weekly hours: | Type of employment:

3. Has the dependant ever attended school? ◯ Yes ◯ No

If **yes**, please give complete details.

Most recent date(s) (dd/mmm/yyyy): | Weekly hours: | Type of school:

Continued on the next page.

3. Dependant information (continued)

4. Is dependant eligible for: a) benefits under a government plan? ◯ Yes ◯ No
   b) Health, Dental, Disability Benefits from another group plan? ◯ Yes ◯ No

If answering **yes** to either of the above questions, please give complete details.

5. Are you the sole means of support for the dependant? ◯ Yes ◯ No

If **no**, please explain.

6. Please confirm if the dependant was covered as an Over-Age Dependant under a previous Group Insurance Plan. If **yes**, please provide details below. ◯ Yes ◯ No

Insurance company: | Policy number: | Certificate number: | Date coverage terminated (dd/mmm/yyyy):

4. To be completed by the attending physician

Physician last name: | First name and initial:

Physician address: | City and province: | Postal code:

Telephone number: ( ) | Fax number: ( ) | Email address:

1. What is the clinical diagnosis, the nature and degree of mental/physical disability? Please provide details.
2. When was the above condition diagnosed? (dd/mmm/yyyy): _____
3. When was the patient last examined? (dd/mmm/yyyy): _____
4. How does the mental or physical disability restrict the patient's ability to engage in normal activities?
5. Does the patient need assistance with activities of daily living? ◯ Yes ◯ No If **yes**, please provide details.
6. What type of work can the patient perform?
7. Please confirm the dates this patient has been unable to work or attend school full-time due to the disability.
8. What is the prognosis?
9. Do you consider the patient to be totally disabled? ◯ Yes ◯ No
10. Is the disability ◯ temporary **or** ◯ permanent?
11. Are there any additional remarks or observations you can provide?

I **declare** that the information in this section is true to the best of my knowledge.

Physician signature: | Date (dd/mmm/yyyy):

5. Plan member signature

I hereby apply for coverage ("Coverage") under the Group Benefits plan issued to my plan sponsor by Manulife. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I understand** that as the applicant, it is my responsibility to ensure that any further verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of our knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** Manulife to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize** my plan sponsor to make deductions from my pay for my Group Benefits plan, if applicable. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at **www.manulife.ca/planmember**, or from my Plan Sponsor.

Please sign and date here.

Plan member signature: _____

Date signed (dd/mmm/yyyy): _____

6. Mailing instructions

Please send the completed form to:

Group Medical Underwriting
Manulife
P.O. Box 1900, Station C
Kitchener Ontario N2G 4R4

Print

Ce document est aussi disponible en français sur demande – GL0514F

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