EMPLOYEE OVER-AGE DEPENDENT QUESTIONNAIRE

INSTRUCTIONS - Please print all answers clearly

1. Plan Member completes sections 1, 2 and 4. Physician completes section 3.
2. This form ***must be completed in full*** to avoid a delay in assessing the application. Once we have all the required information and have completed our assessment, we will notify the plan member in writing.
3. Please retain a copy of this form for your records.
4. **Fees for providing medical information are not covered under your plan.**

Please send the completed form to:

Questions? Call Toll Free: 1.800.957.9777

Medical & Dental Services
The Canada Life Assurance Company
PO Box 6000
Winnipeg MB R3C 3A5

www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511

1. Plan Member Information

Please complete the following:

Plan Number

☐ PS/GE SGEU and CUPE 600
☐ Out-of-Scope Management Employees (168853)

Plan Member I.D. Number
(This number can be located on your 3 in 1 Benefits Card)

Plan member last name

First name

Address

City and province

Postal code

2. Dependent Information

Last name of dependent

First name

Relationship to plan member

Dependent date of birth (mm/dd/yy)

Is the disabled dependent a resident of your home 365 days a year? ☐ Yes ☐ No

If "No", please explain.

Has the dependent ever been employed? ☐ Yes ☐ No

If "Yes", please give most recent dates of employment and description of type of employment.

Start date of employment (mm/dd/yyyy)	End date of employment (mm/dd/yyyy)	Type of employment	How many hours worked per week

Highest level of education attained _____

Is he/she currently attending an educational facility? ☐ Yes ☐ No

If "Yes", name of program/facility _____

If "No", when was the last day attended? _____

If your dependent has had an educational assessment completed in the past, please attach the most recent one to this form.

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3. Attending Physician

Physician name (print) _____

Address _____
Number and Street City or town Province Postal code

Physician specialty _____

1. What is the clinical diagnosis, the nature and degree of this patient's condition? Please provide as much detail as possible and use a separate page if needed. Please also attach all relevant specialist/allied health reports and test results.

2. When was the above condition diagnosed? (mm/dd/yy) _____
3. When was the patient last examined? (mm/dd/yy) _____
4. How does the patient's condition restrict their ability to engage in the activities of daily living?
5. What type of work can the individual perform?
6. Please confirm the date that this patient has been unable to work or attend school full-time due to their condition.
7. What is the prognosis?
8. Please describe the patient's current treatment regime.
9. Please list the patient's medications, route and dosage (use a new page if required).
   1. _____ 5. _____
   2. _____ 6. _____
   3. _____ 7. _____
   4. _____ 8. _____
10. Is/was the patient hospitalized? If yes, please provide date of admittance and discharge summary.
11. Are there any additional remarks or observations you can provide?

Please supply any specialist notes - physical and psychological.

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

Physician's signature _____ Date (mm/dd/yy) _____

4. Authorizations and Declarations

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I authorize Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Please sign and date here.

Plan member's signature _____ Date (mm/dd/yy) _____