CANADIAN BENEFIT PROVIDERS

APPLICATION FOR DISABLED DEPENDANT COVERAGE

- Please ensure ALL SECTIONS are completed, including the section to be completed by physician.
- Section 1, 2 & 4 - To be completed first by Plan administrator
- Section 3 - To be completed by attending physician
- Retain a photocopy for your files.
- Please print clearly and properly fill out each section to avoid delays

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (First Name, Last Name)				DATE OF BIRTH (mm/dd/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | DISABLED DEPENDANT INFORMATION

DEPENDANT NAME (Last Name, First Name, Initial)					
RELATIONSHIP TO PLAN MEMBER		DATE OF BIRTH (mm/dd/yyyy)		SEX	
ADDRESS OF DEPENDANT (if different from Plan Member)					
CITY		PROVINCE		POSTAL CODE	

1. IS THE DISABLED DEPENDANT A RESIDENT OF YOUR HOME 365 DAYS A YEAR? YES ☐ NO ☐ IF "NO", PLEASE EXPLAIN.

2. HAS THE DISABLED DEPENDANT EVER BEEN EMPLOYED? YES ☐ NO ☐
IF "YES", PLEASE GIVE MOST RECENT DATE OF EMPLOYMENT AND DESCRIPTION OF TYPE OF EMPLOYMENT.

DATE (mm/dd/yyyy)		TYPE OF EMPLOYMENT	

3. IS THE DISABLED 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.

4. ARE YOU THE SOLE MEANS OF THE DISABLED DEPENDANT'S SUPPORT? YES ☐ NO ☐ IF "NO", PLEASE EXPLAIN.

5. PLEASE CONFIRM IF THE DEPENDANT WAS COVERED AS AN OVER-AGE DISABLED DEPENDANT UNDER A PREVIOUS GROUP INSURANCE PLAN.

INSURANCE COMPANY	POLICY NUMBER	CERTIFICATE NUMBER	DATE COVERAGE TERMINATED (mm/dd/yyyy)

PART 3 | TO BE COMPLETED BY THE ATTENDING PHYSICIAN

PHYSICIAN NAME (Last Name, First Name)					
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
WORK		FAX			
EMAIL					

1. WHAT IS THE CLINICAL DIAGNOSIS, THE NATURE AND DEGREE OF MENTAL/PHYSICAL HANDICAP? PLEASE PROVIDE DETAILS.			
2. WHEN WAS THE ABOVE CONDITION DIAGNOSED? (mm/dd/yyyy)		3. WHEN WAS THE PATIENT LAST EXAMINED? (mm/dd/yyyy)	
4. HOW DOES THE MENTAL OR PHYSICAL HANDICAP RESTRICT THE INDIVIDUAL'S ABILITY TO ENGAGE IN NORMAL ACTIVITIES?			
5. WHAT TYPE OF WORK CAN THE INDIVIDUAL PERFORM?			
6. PLEASE CONFIRM THE DATES THIS PATIENT HAS BEEN UNABLE TO WORK OR ATTEND SCHOOL FULL-TIME DUE TO THE DISABILITY.			
7. WHAT IS THE PROGNOSIS?			
8. ARE THERE ANY ADDITIONAL REMARKS OR OBSERVATIONS YOU CAN PROVIDE?			

PHYSICIAN SIGNATURE	DATE (mm/dd/yyyy)

PART 4 | PLAN MEMBER SIGNATURE

Whereas the "Company" refers to Canadian Benefit Providers Inc., I certify that the information in this form is true and complete to the best of my 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 the collection, use, maintenance and disclosure of 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 my Plan Advisor, its reinsurers and/or its service providers, for the Purposes. I understand that any Information provided to or collected 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: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law.

PLAN MEMBER'S SIGNATURE	DATE

Forward this completed form by email, fax or mail to:
Email | admin@cbproviders.ca
Fax | 1.844.944.9168
Mail | Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada

Questions?
Call us at 780.944.9166 ext 280, or toll free at 1.855.944.9166 ext 280
Email | helpdesk@cbproviders.ca