Application for Overage Disabled Dependent Coverage

Instructions
Please print all answers

1. Contact Manion for coverage eligibility guidelines under your plan.
2. Please ensure ALL sections are completed, including the section to be completed by a physician.
   Section 1 – To be completed by the plan administrator
   Section 4 - To be completed by a physician.
   Section 2, 3, 5 – To be completed by the plan member.
3. If required, please retain a photocopy for your files.

1 – Plan Administrator Information *To be completed by Manion.*	Plan name		Plan member division
	Plan policy number	Plan member certificate #	Plan member name
	I have reviewed the terms of over-age dependent coverage as outlined in the booklet. I confirm that the undersigned plan member and dependent meet the criteria required to qualify for this coverage. Plan Administrator's Signature:		Date (DD/MM/YYYY):

Please complete the following:

2 – Plan Member Information	Plan member last name	Plan member first name		Middle initial
	Address	City	Prov	Postal code
	Dependent last name	Dependent first name		
	Relationship to plan member	Dependent date of birth (DD/MM/YYYY)		Sex
	Address of dependent (if different from member)	City	Prov	Postal Code

3 – Disabled Dependent Information	Is the disabled dependent a resident of your home 365 days a year? O Yes O No If "No", please explain:		
	What is the highest level of education the disabled dependent has obtained?		
	Has the disabled dependent ever been employed? O Yes O No If "Yes", please give most recent date of employment and description of type of employment. Date (DD/MM/YYYY): Type of employment:		
	Is the disabled dependent eligible for:	a) Benefits under a government plan? O Yes O No b) Health, Dental, or Disability benefits from another plan? O Yes O No	
	If answering "Yes" to either of the above questions, please provide complete details:		
	Are you the sole means of support for the disabled dependent? O Yes O No If "No", please explain:		
	Please confirm if the disabled dependent was covered as an over-age dependent under a previous Group Insurance Plan.		

Insurance company	Policy number	Certificate number	Date coverage terminated (DD/MM/YYYY)

4 – To be completed by the attending physician	Physician last name		Physician first name		Middle initial
	Physician address		City	Prov	Postal code
	Telephone number	Fax number	Email address		
	1. What is the clinical diagnosis, the nature and degree of the mental/physical handicap? Please provide details.				
	2. When was the above condition diagnosed? (DD/MM/YYYY)		3. When was the patient last examined? (DD/MM/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 individual has been unable to work or attend school full-time due to the disability.				
	7. Do you consider the patient totally disabled? O Yes O No Effective: (DD/MM/YYYY)				
	8. Is this disability: O temporary O permanent? What is the probable duration of the disability?				
	9. In the event of a functional impairment, specify the impairment: O Intellectual O O Language – speech O Organic O Mental O Hearing (attach the hearing test) O Vision (attach the vision test) O Motor O Multiple Specify: Is the impairment: O Temporary O Permanent				
	10. 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's signature: Date (DD/MM/YYYY):				
5 – Plan member signature	I hereby apply to coverage under the group benefits plan issued to my plan sponsor. I understand that certain aspects of said coverage may extend to my spouse and/or eligible dependents. 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 written or verbal statement provided by me, and/or my dependents, 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 to collect, use, maintain and disclose personal information relevant to this application for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility. 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 Manion 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 agree a photocopy or electronic version of this authorization is valid. I understand that any Information provided to or collected by Manion 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 Manion employees, representatives, 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 Manion collects, uses, maintains, and discloses my personal information can be found in our Privacy Policy available at Manion.com				
Please sign and date here.	Plan Member's signature: Date (DD/MM/YYYY):				

Mailing instructions
Please send the completed form to:

Manion Wilkins & Associates
500 - 21 Four Seasons Place
Toronto, ON M9B 0A5
Attn: Administration Dept