# Retiree Plans

Johnston group

JG100-JG

## REQUEST FOR OVER-AGE DISABLED DEPENDENT COVERAGE

**Please indicate your Firm & Certificate #**

| Firm # | Certificate # |
|---|---|
| | |

Covered Individual's Name _____

Dependent's Name _____ Covered Individual'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 Canada Revenue Agency Notice of Assessment 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 Notice of Assessment.

**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. I acknowledge that no benefits will be payable until the insurer approves this application. I authorize Co-operators Life Insurance Company, Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. 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.johnstongroup.ca. A photocopy of this authorization is as valid as the original.

Covered Individual's Signature _____ Date _____

**NATIONAL SERVICE CENTRE**
**1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1-800-893-7587**

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# ATTENDING PHYSICIAN STATEMENT

(To be completed by the disabled dependent's attending physician. The Covered Individual assumes responsibility for any costs associated with the completion of this form.)

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 (_____)_____

Signature _____ Date _____