❑ Claim Pending

ContinYou™

JG100-CY

REQUEST FOR OVER AGE DISABLED DEPENDENT COVERAGE

Please print your Policy & Certificate #

Policy #	Certificate #

This form is to be completed by the covered individual to request coverage to be extended for a disabled dependent over age 21. This form must be accompanied by a report or letter from the dependent's personal physician confirming the date of onset of the disability, the diagnosis and prognosis for the dependent, and the extent to which the physician determines the dependent is unable to work.

Covered Individual's Name _____

Dependent's Name _____ Birth Date _____
YYYY/MM/DD

1. Is the dependent financially dependent upon you 365 days per year? ❑ Yes ❑ No
2. Has the dependent ever been employed? ❑ Yes ❑ No

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

   _____

3. Is the dependent eligible for:

   a) benefits under a government plan? ❑ Yes ❑ No

   b) Health or Dental benefits from another plan? ❑ Yes ❑ No

   If "Yes" to either question, please give full details:

   _____

4. Are you the dependent's sole means of support? ❑ Yes ❑ No

   If no, please explain:

   _____

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, and I certify that the dependent child identified is totally and permanently disabled. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Johnston Group Inc. to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining plan eligibility. 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 or from the administrator of my benefit program.

A photocopy of this authorization is as valid as the original.

Employee's Signature _____ Date _____

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