Retiree Plans
Johnston group

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. Any copy of this authorization shall be 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

Health and dental insurance is underwritten by Co-operators Life Insurance Company and administered by Johnston Group Inc. Travel insurance is underwritten by CUMIS General Insurance Company, a member company of The Co-operators Group Limited, and is administered by Allianz Global Assistance, which is a registered business name of AZGA Service Canada Inc. and AZGA Insurance Agency Canada Ltd.

Retiree Plans

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

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2) Nature and degree of disability

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3) Impairment or restrictions resulting from the condition

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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?

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Physician Information

Name ______________________________ Specialization ______________

Address ______________________________

Phone (______)______________

Signature ______________________________ Date ______________