Group Benefits
Application for Over-Age Disabled Dependant Coverage

INSTRUCTIONS – Please print all answers

1. *Please consult your plan administrator for coverage eligibility guidelines under your plan.*
2. *Please ensure ALL SECTIONS are completed, including the section to be completed by physician.*
   Section 1 - To be completed first by plan administrator
   Section 4 - To be completed by attending physician
   Section 2, 3 & 5 - To be completed by plan member
3. *If required, retain a photocopy for your files.*

1 Plan sponsor information

Plan sponsor name	Plan contract number(s)	Plan member account/division

Plan sponsor address	Plan member certificate number	Plan member name

Self administered plan administrators please read and complete.

I have reviewed the terms of over-age dependant coverage as it is outlined in our contract with Manulife Financial. I confirm that the undersigned plan member and dependant fit the eligibility criteria required to qualify for this coverage.

Plan administrator's signature	Date (dd/mmm/yyyy)	Plan administrator email

2 Plan member information

Please complete the following.

Plan member last name	First name	Middle initial

Address	City and province	Postal code

Last name of dependant	First name

Relationship to plan member	Dependant date of birth (dd/mmm/yyyy)	Sex

Address of dependant if different from plan member	City and province	Postal code

3 Disabled dependant information

Is the disabled dependant a resident of your home 365 days a year? ◯ Yes ◯ No
If "No", please explain.

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 (dd/mmm/yyyy)	Type of employment

Is 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.

Are you the sole means of the disabled dependant's support? ◯ Yes ◯ No
If "No", please explain.

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 (dd/mmm/yyyy)

4 To be completed by the attending physician