Plan Administration Office Address
45 McIntosh Drive
Markham, ON L3R 8C7
Phone: 1-800-668-7547 Fax: 1-905-946-2535
E-Mail: medical@boilermakersbenefits.ca

REQUEST OVER-AGE DISABLED DEPENDANT COVERAGE

BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

PLAN MEMBER AND DISABLED DEPENDANT CONTACT INFORMATION

PLAN MEMBER'S FIRST AND LAST NAME	PLAN MEMBER'S SOCIAL INSURANCE NUMBER	PLAN MEMBER'S E-MAIL ADDRESS
LAST NAME OF DEPENDANT	FIRST NAME OF DEPENDANT	MIDDLE INITIAL OF DEPENDANT
DATE OF BIRTH OF DEPENDANT	RELATIONSHIP TO PLAN MEMBER	SEX OF DEPENDANT (M/F)
STREET ADDRESS OF DEPENDANT	CITY, PROVINCE	POSTAL CODE

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 THE TYPE OF EMPLOYMENT:

_____

IS THE DISABLED DEPENDANT ELIGIBLE FOR

A) BENEFITS UNDER A GOVERNMENT PLAN? ☐ **YES** ☐ **NO**

B) HEALTH, DENTAL, DISABLILITY 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 (D/M/YR):	

THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN

PHYSICAN'S LAST NAME	PHYSCIAN'S FIRST NAME
PHYSICIAN'S STREET ADDRESS	CITY/PROVINCE/POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

WHAT IS THE CLINICAL DIAGNOSOS, THE NATURE AND DEGREE OF MENTAL/PHYSICAL HANDICAP? (PLEASE PRODIVDE DETAILS)

_____

_____

WHEN WAS THE ABOVE CONDITION DIAGNOSED? (D/M/YR)

_____

WHEN WAS THE PATIENT LAST EXAMINED? (C/M/YR)

_____

HOW DOES THE MENTAL OR PHYSICAL HANDICAP RESTRICT THE INDIVIDUAL'S ABILITY TO ENGAGE IN NORMAL ACTIVITIES?

_____

WHAT TYPE OF WORK CAN THE INDIVIDUAL PERFORM?

_____

PLEASE CONFIRM THE DATES THIS PATIENT HAS BEEN UNABLE TO WORK OR ATTEND SCHOOL FULL-TIME DUE TO THE DISABILITY?

_____

WHAT IS THE PROGNOSIS?

_____

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.

PHYSICAN'S SIGNATURE: _____

DATE SIGNED (D/M/YR): _____

PLAN MEMBER SIGNATURE

I hereby apply for coverage under the Boilermakers' National Benefit Plans (Canada). I understand that certain aspects of such coverage extend to my spouse and eligible dependants. 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 verbal or written statement provided by me, and/or my Dependants, in the future is true and complete to the best of my knowledge. I acknowledge and agree that this coverage or any portion of this coverage, and future claims hereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. I authorize the Boilermakers' National Benefit Plan (Canada) to collect, use, maintain and disclose personal information relevant to this application for the purposes of plan administration, audit, assessment, investigation, claim information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, investigative agency, and any other administrators of other benefit programs. 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. I authorize the use of my Social Insurance Number ("SIN") for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid.

PLAN MEMBER SIGNATURE: _____

DATE SIGNED (D/M/YR): _____

MAILING INSTRUCTIONS (ONCE COMPLETED, PLEASE RETURN ALONG WITH ANY ORIGINAL PAID RECIEPTS)

BOILERMAKERS' NATIONAL BENEFIT PLANS (CANADA) ADMINISTRATION OFFICE:	TELEPHONE NUMBERS:	FAX NUMBER:	E-MAIL ADDRESS:
45 MCINTOSH DRIVE MARKHAM, ON L3R 8C7	1-905-946-2530 1-800-668-7547	1-905-946-2535	MEDICAL@BOILERMAKERSBENEFITS.CA

Privacy Statement: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal information will be protected pursuant to applicable legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, unions, regulators, legal counsel, actuaries etc.) in order to manage the Plan and your entitlement to the Benefits of the Plan.

Questions related to the Privacy Policy of the Plan should be direct to the Plan Administration Office at 1-800-668-7547