

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

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

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

○ ○
○ ○

If answering "Yes" to either of the above questions, please give complete details.

Are you the sole means of the disabled dependant's support? ○ ○
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	

4 To be completed by the attending physician

Physician - last name	First name and initial