Pensioners' Dental Services Plan

Application for Dependant with a Disability Coverage

PROTECTED "B" WHEN COMPLETED

Part 1 – Instructions

Please use this form to submit your application for a dependant with a disability to Canada Life.

1. Complete Parts 2 to 6 in full and have your attending physician or nurse practitioner complete Parts 7 and 8.
2. Include any supporting documents from educational institutions or medical professionals that will help support your application (if applicable).
3. Send to Canada Life. See Part 9.

Please note that physician's fees for providing medical information are not covered under the Pensioners' Dental Services Plan (PDSP).

All forms under the PDSP must be submitted through the plan member. We may disclose personal information about claims with your employer, your service provider and/or a person acting on your behalf when necessary to confirm eligibility and to mutually manage the claim.

Part 2 – Plan member's information – You must complete this section fully. If you are unsure of your plan or certificate number, please see your PDSP benefit card, the Canada Life PDSP Member Services website or Part 9 for our contact information.

Plan name: **Pensioners' Dental Services Plan** | Plan number | Plan member certificate number

Plan member's name

First name | Last name

Plan member's address

Number and street | City or town | Province/Territory/State | Postal/Zip Code

Country | **Date of birth** Day | Month | Year

Part 3 – Dependant's information

First name | Last name

Relationship to plan member | **Date of birth** Day | Month | Year | Dependant's marital status ☐ Single ☐ Married/Common-law ☐ Other: ____________

Residence of dependant (if different from plan member)

Number and street | City or town | Province/Territory/State | Postal/Zip Code

If the dependant is not a resident of your home 365 days a year, please explain.

Dependant's education

Highest level of education attained: ____________

Is the dependant currently attending an educational institution? ☐ Yes ☐ No

If "Yes": Is the dependant attending full time? ☐ Yes ☐ No

Anticipated program completion date: Day | Month | Year

Name of program and institution: ____________

If "No": Name of last program and institution attended, last day of attendance and reason for end of attendance.

Dependant's employment

Has the dependant ever been employed? ☐ Yes ☐ No If "Yes" please provide the most recent date(s) and type(s) of employment.

Period of employment (mmm-dd-yyyy) to (mmm-dd-yyyy)	Employer	Job title	Average monthly income	Hours worked per week	Reason for leaving employment, if applicable

Is the dependant incapable of engaging in self-sustaining employment and primarily dependent on the plan member for support and maintenance? ☐ Yes ☐ No If yes, is there an anticipated date of return to school/work? Day | Month | Year

M7450(PDSP)-8/24

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.

Part 3 – Dependant's information, continued

Plan member's statement

In your own words, describe the dependant's activities on an average day, for example, socializing, transportation, eating or personal hygiene. Please attach an additional page if further space is required.

Additional documents

We encourage you to attach any available supporting documents from educational institutions or medical professionals that will help support your application. Examples include:

- recent educational assessments
- recent cognitive assessments or neuropsychological reports
- clinical notes or specialist reports issued in the past year

Part 4 – Coordination of benefits – Complete this section to indicate whether the dependant has dental benefits coverage under any other plan. This information will be used to determine if the application has been previously assessed under any other benefit plan.

1. Is your dependant entitled to any other dental insurance? ☐ Yes ☐ No
   If yes, please answer the questions below.
2. If the other insurance plan belongs to your spouse, common-law partner or dependant child's other parent/legal guardian, please provide their date of birth. Day ____ Month ____
3. Is the other insurance also with Canada Life? ☐ Yes ☐ No
   If yes, please provide: Plan number: ____________ Certificate number: ____________
   Other insurance plan member's signature of authorization: X ____________
4. Has the dependant ever been covered as a dependant with a disability under any other Canada Life plan? ☐ Yes ☐ No
   If yes, please provide: Plan number: ____________ Certificate number: ____________

Part 5 – Privacy

At Canada Life, we recognize and respect the importance of privacy. Personal information we collect will be used to assess your claim and administer the group benefits plan. Please refer to the PDSP Privacy Statement (https://www.canada.ca/en/treasury-board-secretariat/topics/benefit-plans/plans/pensioner-dental-services-plan/resources/pensioners-dental-services-plan-privacy-statement.html) for further information on how your privacy is protected. Where there is a difference between the Privacy Act (//laws-lois.justice.gc.ca/eng/acts/P-21/) and the PDSP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to canadalife.com.

Part 6 – Confirmation, Authorization and Signature

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority (for the PSHCP only), Dental Board/Boards of Management (for the PSDCP and/or PDSP - whichever plans you are enrolled in with Canada Life), other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pdsp/positive-enrolment/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP, PSDCP and/or PDSP Privacy Statement(s) (whichever plans you are enrolled in with Canada Life).

For the purposes of appeals, audits, or in the case of overpayments and/or erroneous payments which I have not reimbursed to Canada Life, I agree that Canada Life may disclose personal information related to such payment to the Plan Sponsor, the Treasury Board of Canada Secretariat, and the Federal PSHCP Administration Authority (for the PSHCP only), Dental Board/Boards of Management (for the PSDCP and/or PDSP - whichever plans you are enrolled in with Canada Life). The Plan Sponsor/Treasury Board of Canada Secretariat may disclose this personal information to government institutions so that the overpayments and/or erroneous payments and associated interest (if applicable) can be deducted or set-off from any money due or payable to me by His Majesty. I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan. The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

Plan member's signature X ____________ **Date** Day ____ Month ____ Year ____

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

Pensioners' Dental Services Plan
Application for Dependant with a Disability Coverage

PROTECTED "B" WHEN COMPLETED

Part 7 – Attending physician's or nurse practitioner's statement – for completion by the medical professional

Primary diagnosis: ______________________ Date of diagnosis: Day ___ Month ___ Year ___

Secondary diagnosis: ______________________ Date of diagnosis: Day ___ Month ___ Year ___

Secondary diagnosis: ______________________ Date of diagnosis: Day ___ Month ___ Year ___

Functional abilities

Does the patient have physical impairments? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? ______________________

Does the patient have cognitive impairments? ☐ Yes ☐ No Are the impairments permanent? ☐ Yes ☐ No ☐ N/A

If the impairments are not permanent, when are they expected to resolve or improve? ______________________

Is there an expected date when the patient will be able to return to school or enter the workforce? ☐ Yes ☐ No

Date: Day ___ Month ___ Year ___

Please describe the nature and severity of any cognitive impairments.

____

Does the patient have impairments in any of the following areas?

Area	Yes	No	Details
Sitting	☐ Yes	☐ No	Details: ______
Ambulation	☐ Yes	☐ No	Details: ______
Lifting or carrying	☐ Yes	☐ No	Details: ______
Manual dexterity	☐ Yes	☐ No	Details: ______
Speech	☐ Yes	☐ No	Details: ______
Hearing	☐ Yes	☐ No	Details: ______
Vision	☐ Yes	☐ No	Details: ______

Indicate whether your patient requires assistance managing any of the following, and if so, describe supports needed:

Personal care or hygiene *(for example, bathing, dressing)*

☐ Yes ☐ No Describe the support needed: ______________________

Self-care or independent care *(for example, manage medications, schedule and attend medical appointments)*

☐ Yes ☐ No Describe the support needed: ______________________

Personal finances *(for example, banking, paying bills, budgeting)*

☐ Yes ☐ No Describe the support needed: ______________________

Home care *(for example, cooking, cleaning, grocery shopping)*

☐ Yes ☐ No Describe the support needed: ______________________

Transportation *(for example, driving or public transit with or without assistive devices)*

☐ Yes ☐ No Describe the support needed: ______________________

Routine or schedule *(creating and adhering to a schedule)*

☐ Yes ☐ No Describe the support needed: ______________________

Decision making *(using judgement to make good decisions)*

☐ Yes ☐ No Describe the support needed: ______________________

Cognitive competencies *(ability to set goals, problem solve, appropriate decision making)*

☐ Yes ☐ No Describe the support needed: ______________________

Toileting and continence *(independent transfers, self care, hygiene or assistance required)*

☐ Yes ☐ No Describe the support needed: ______________________

Please describe the type of work the patient can perform.

____

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company.
Any modification of this document without the express written consent of Canada Life is strictly prohibited.

canada life™

Pensioners' Dental Services Plan

Application for Dependant with a Disability Coverage

PROTECTED "B" WHEN COMPLETED

Part 7 – Attending physician's or nurse practitioner's statement, continued – for completion by the medical professional

Treatment (include medications, therapies and other treatments)

Date of last appointment: Day ____ Month ____ Year ____ Date of next appointment: Day ____ Month ____ Year ____

Describe the current treatment plan (use a separate page if necessary).

____

____

____

Medications: ______________________________

Therapies: ______________________________

List any other physicians or care providers involved in the patient's treatment (use a separate page if necessary).

Name	Specialty	Address

Prognosis: ______________________________

Provide any other comments you feel would assist us in understanding the patient's situation.

____

Part 8 – Attending physician's or nurse practitioner's confirmation and signature

I certify that the information given on this application form is true, correct and complete to the best of my knowledge.

Physician's or nurse practitioner's name

Name ____ Phone number ____

Physician's or nurse practitioner's address

Number and street ____ City or town ____ Province/Territory/State ____ Postal/Zip Code ____

Signature X ______________________________ **Date** Day ____ Month ____ Year ____

Part 9 – Submitting your application

Please send the completed form to:

EMAIL

medicalservices@canadalife.com

MAIL

The Canada Life Assurance Company
Medical and Dental Claims Management
PO Box 6000
Winnipeg MB R3C 3A5

FAX

1-204-938-2820

Questions? Call Canada Life:
North America (toll-free): 1-855-415-4414
Monday to Friday from 8 am to 5 pm, your local time.
International (collect): 1-431-489-4064

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711
Voice to TTY: 1-800-855-0511

M7450(PDSP)-8/24

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.