

**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 part 7 and 8.
2. Include any supporting documents from education 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 Public Service Health Care Plan (PSHCP).

All forms under the Public Service Health Care Plan (PSHCP) 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.

**You must complete a separate application form under the PSDCP, PDSP, and PSHCP.** Visit 'Your Forms' page under the applicable plan on the Member Services websites.

**PART 2 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your Public Service Health Care Plan (PSHCP) benefit card, the Canada Life PSHCP Member Services website or Part 9 for our contact information.**

Plan name <b>Public Service Health Care Plan</b>	Plan number	Plan member certificate number	
<b>Plan member name</b>			
First name	Last name		
<b>Plan member address</b>			
Number and street	City or town	Province/Territory/State	Postal/Zip Code
Country	<b>Date of birth</b>	Day	Month
		Year	

**PART 3 – Dependant information**

First name	Last name		
Relationship to plan member	<b>Date of birth</b>	Day	Month
		Year	Marital status
			<input type="checkbox"/> Single <input type="checkbox"/> Married/Common-law <input type="checkbox"/> Other: _____
<b>Residence of dependant (if different from plan member)</b>			
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.			
<b>Dependant's education</b>			
Highest level of education attained: _____		Is the dependant currently attending an educational facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes": Is the dependant attending full time? <input type="checkbox"/> Yes <input type="checkbox"/> No		Anticipated program completion date: Day Month Year	
Name of program and facility _____			
If "No": Name of last program and facility attended, last day of attendance and reason for end of attendance.			
<b>Dependant's employment</b>			
Has the dependant ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**PART 3 – Dependant information, continued**

**Plan member's statement**

In your own words, describe the dependant's activities on an average day, such as socializing, transportation, eating, personal hygiene, etc. 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 you or any member of your family have benefit coverage under any other plan.

1. Are you or any member of your family entitled to any other health insurance plan benefits?  Yes  No  
If yes, please answer the questions below.
2. Who does the other insurance belong to?  Self  Spouse or common-law partner  Dependant child  
First name \_\_\_\_\_ Last name \_\_\_\_\_
3. If the other insurance plan belongs to your spouse or common-law partner and the claimant is a dependant child, please provide your spouse or common-law partner's date of birth. Day  Month
4. Is the other insurance also with Canada Life?  Yes  No  
If yes, please provide: Canada Life plan number \_\_\_\_\_ Certificate number \_\_\_\_\_  
Other insurance plan member's signature of authorization: X \_\_\_\_\_
5. 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 \_\_\_\_\_

**You must complete a separate application form under the PSDCP, PDSP, and PSHCP.** Visit 'Your Forms' page under the applicable plan on the Member Services websites.

**PART 5 – Privacy**

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your application and administering the group benefits plan. Please refer to the PSHCP Privacy Statement ([canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html](http://canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/public-service-health-care-plan-privacy-statement-september-2009.html)) for further information on how your privacy is protected.

Where there is a difference between the [Privacy Act](http://laws-lois.justice.gc.ca/eng/acts/P-21/) ([//laws-lois.justice.gc.ca/eng/acts/P-21/](http://laws-lois.justice.gc.ca/eng/acts/P-21/)) and the PSHCP 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](http://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, 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/pshcp/review-authorizations-and-declarations.html](http://welcome.canadalife.com/pshcp/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 Privacy Statement.

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

Plan member signature X \_\_\_\_\_ Date Day  Month  Year

**PART 7 – Attending physician's or nurse practitioner's statement**

Primary diagnosis: \_\_\_\_\_ Date of diagnosis (mmm-dd-yyyy): \_\_\_\_\_  
 Secondary diagnosis: \_\_\_\_\_ Date of diagnosis (mmm-dd-yyyy): \_\_\_\_\_  
 Secondary diagnosis: \_\_\_\_\_ Date of diagnosis (mmm-dd-yyyy): \_\_\_\_\_

**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? \_\_\_\_\_

Please describe the nature and severity of any cognitive impairments.  
 \_\_\_\_\_

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

- 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 (*bathing, dressing, toileting, etc.*)  
 Yes  No      Describe the support needed: \_\_\_\_\_
- Treatment (*taking medications, attending appts, etc.*)  
 Yes  No      Describe the support needed: \_\_\_\_\_
- Personal finances (*banking, paying bills, budgeting, etc.*)  
 Yes  No      Describe the support needed: \_\_\_\_\_
- Home care (*cooking, cleaning, grocery shopping, etc.*)  
 Yes  No      Describe the support needed: \_\_\_\_\_
- Transportation (*driving, taking bus, etc.*)  
 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: \_\_\_\_\_
- Planning (*ability to plan for the future*)  
 Yes  No      Describe the support needed: \_\_\_\_\_

Please describe the type of work the patient can perform.  
 \_\_\_\_\_

**PART 7 – Attending physician’s or nurse practitioner’s statement, continued**

**Treatment (include medications, therapies, and other treatments)**

Date of last appointment (mmm-dd-yyyy): \_\_\_\_\_ Date of next appointment (mmm-dd-yyyy): \_\_\_\_\_

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

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 claim form is true, correct and complete to the best of my knowledge.

**Physician or nurse practitioner’s name**

Name	Phone number
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**Physician or nurse practitioner’s address**

Number and street	City or town	Province/Territory/State	Postal/Zip Code
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Signature X _____	Date	Day	Month	Year
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**PART 9 – Submitting your application**

Please send the completed form to:

**EMAIL**

[medicalservices@canadalife.com](mailto:medicalservices@canadalife.com)

**MAIL**

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

**FAX**

1-204-938-2820

**Questions? Call Canada Life:**

Call toll free 1-855-415-4414  
Monday to Friday from 8 am to 5 pm, your local time.



**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