

**APPLICATION FOR TOTAL AND PERMANENT
DISABILITY STATUS FOR A DEPENDENT CHILD**
PARTICIPANT STATEMENT

The participant must complete all questions in section 1 and 2 of this form in full and must sign and date the authorization.
The participant accepts full and sole responsibility for any costs associated with the completion of this form.

1 General Information

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Policy No

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Participant's Certificate No or Social Insurance Number

Name of Participant

Surname

Given Name(s)

Name of Dependent Child

Surname

Given Name(s)

 Child's date of birth

D	D	M	M	Y	Y	Y	Y
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 Date last attended school, if applicable

D	D	M	M	Y	Y	Y	Y
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Level of education attained including any courses completed or certificates earned: _____

2 Medical Information

Nature of total and permanent disability: _____

 Date of onset of disability

D	D	M	M	Y	Y	Y	Y
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a) Record of employment history and work experience:

Please describe the limiting factors which prevent the dependent child from performing remunerated work.

b) Does the dependent qualify for government assistance due to his/her handicap?

 Yes No

If an application was made, please indicate the outcome (approved or denied) and provide a copy of all documentation submitted to and received from the government.

c) Is the dependent child being claimed on the income tax return of the participant or his/her spouse?

 Yes No

If yes, please provide a copy of your Notice of Assessment. If no, please explain why:

3 Authorization and Signature

I authorize the release of any information or records requested in respect of this application to The Standard Life Assurance Company of Canada. I certify that the dependent child identified in this form is totally and permanently disabled. The information I have provided on this form is true, correct and complete to the best of my knowledge.

I consent to the use of my Social Insurance Number as my certificate number, and understand that it is my responsibility to advise my Plan Administrator if I prefer to use another identification number.

I confirm being authorized by my dependents to act on their behalf.

Participant's Signature

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Date

ATTENDING PHYSICIAN STATEMENT

The participant is responsible for ensuring the completion of this form by the Attending Physician and for any associated costs. The physician must return the completed form to the participant.

1 Diagnosis of patient's present condition

2 Impairment resulting from this condition

 Permanent Temporary

3 Type and frequency of medication / treatment prescribed

a) Summary of medical and therapeutic interventions related to the condition:

b) Current and planned treatments and therapy:

4 Please provide copies of all specialist assessments (including pediatric, neurologist, physiatrist, psychiatrist, psychologist, occupational therapist, speech therapist, physiotherapist, etc.), consultation letters, progress reports, ambulatory outpatient records and clinical notes

5 Date patient became incapable of self-support

D	D	M	M	Y	Y	Y	Y
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6 Prognosis of patient's present condition

7 Physician Information

Surname

Specialization

Address

Physician's Signature

Given Name(s)

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Telephone No.

D	D	M	M	Y	Y	Y	Y
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Date