Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Disabled Dependent Declaration

Send form to:
Email: claims@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

PART A) TO BE COMPLETED BY EMPLOYEE

This form is to be completed by the employee to inform Health Risk Services of any disabled dependents.

Part A is to be completed by the employee, Part B is to be completed by a registered and licensed physician.

Eligibility is based on the below criteria:

- the dependent has a developmental or physical disability, regardless of age, and the employee provides satisfactory proof to Health Risk Services Inc. of the dependent child's disability within 31 days of the Benefits plan's limiting age of 21, and as required thereafter

EMPLOYEE INFORMATION

Last Name:	First Name:	DOB: (mm/dd/yy)	Employer:	Group Number:	ID Number:

Address:	City:	Province:	Postal Code:

DEPENDENT INFORMATION

Last Name:	First Name:	DOB:)mm/dd/yy)	Is the dependent living with you and wholly dependent on you for support?
			◯ Yes ◯ No

Has a disability tax credit certificate been sent to, and approved by the Canadian Revenue Agency (CRA) for income tax purposes?
◯ Yes ◯ No - ***If yes, please include a copy of any approval documents from the CRA when returning this form.***

ACKNOWLEDGEMENT AND CONSENT

- I agree that a photocopy or electronic copy of the Authorization and Declarations section is as valid as the original.
- I give permission to Health Risk Services Inc. to continue educating me regarding my benefits program and/or any additional products and services available to myself and my family through Health Risk Services. I am aware that this information may be forwarded through my employer, to my personal residence or by personal/business emails that have been provided.
- I have included all necessary documents to accompany this eligibility form.
- I confirm that I am legally authorized to act on behalf of my dependent and consent to this authorization on their behalf in relation to their personal information.
- I authorize the release of medical and health information in my dependent's file to Health Risk Services Inc. or its authorized agents for the purpose of assessing this request and administering the Benefits plan. This medical and health information includes, but it not limited to, copies of all consultation reports, clinical notes, test results and hospital records.

I understand:

- I can revoke this consent at any time, but without it, this declaration is incomplete and will not be considered.
- I am responsible for any fees related to the completion of any release forms.
  Medical and health information excludes genetic test results.

BY INITIALING HERE, I HEREBY AUTHORIZE:

☐ ***Required**

Health Risk Services, any healthcare provider, my plan administrator, other insurance or re-insurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with Heath Risk Services to exchange personal information, when necessary to determine my eligibility for coverage and to continue to administer the plan.

I certify that all information I have given is true, correct and complete to the best of my knowledge. I understand that the submission of fraudulent information is a criminal offence. Suspected fraudulent activity may be reported to the employer/plan sponsor and to the appropriate law enforcement agency.

EMPLOYEE SIGNATURE

Authorized Signature:	Date Signed (mm/dd/yy):

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PART B) TO BE COMPLETED BY PHYSICIAN

Nature of the disability	Date disability began: (mm/dd/yy)

1) What is the clinical diagnosis, nature and degree of the mental/physical disability? Please provide details:

2) How does the mental/physical disability restrict the individual's ability to engage in normal activities?

3) Does the individual require assistance with activities of dailiy living, such as bathing, dressing, feeding, toileting, transferring, or continence?
◯ Yes ◯ No - *If yes, please provide details*

4) Is the individual capable of working for remuneration or profit?
◯ Yes ◯ No - *If yes, please provide details*

5) What is the prognosis?

6) Is the condition: ◯ Permanent and stationary **OR** ◯ Improvement is anticipated
- Expected date the individual will be able return to work/ school: (mm/dd/yy)

7) Additional remarks/observations:

- The information in this statement will be kept in a file with the Benefits provider and may be accessible by the patient or third parties to whom access has been granted, or those authorized by law.
- By providing the information, I consent to such unedited release of any information contained herein.
- **I delcare that the information provided above is full and true.**

Physician's Name (Please print) Last Name: First Name:	Address: City:	Province:	Postal Code:
Phone Number:	Fax:	Email Address:	

PHYSICIAN SIGNATURE

Physician Signature:	Date Signed: (mm/dd/yy)