DEPENDENT WITH SPECIAL NEEDS ELIGIBILITY FORM

THE CONSTRUCTION INDUSTRY'S BENEFIT PLAN

Plan Member ID: _____ Date: _____

Billing Division #: _____ Contract Reference Code: CIBP

I, _____ request the addition and/or continuation of coverage of

_____ as a *Dependent with Special Needs* to my benefits plan.
(Name of Dependent)

Dependent Date of Birth: _____
YYYY-MM-DD

Date of Disability: _____
YYYY-MM-DD

Please complete the questionnaire below, and return it to:

benefits@mycibp.ca

This dependent is mentally or physically disabled and a disability tax credit for a dependent age 18 or over can be claimed by me under the Income Tax Act. ☐ YES ☐ NO

AND

This dependent is unmarried, unemployed, and financially dependent upon me. ☐ YES ☐ NO

AND

This dependent lives with me or resides in an institution or group home. ☐ YES ☐ NO

OR

This dependent does not reside with me due to divorce or separation. ☐ YES

Proof may be requested to substantiate any of the requirements, which could include:

- Medical assessment indicating date of disability, extent of disability, and attestation that dependent cannot be gainfully employed;
- Copy of tax assessment;
- Proof of residency (government ID with address, affidavit)

By signing this form I agree that the information provided is complete and accurate. Failure to disclose, or falsifying information, could result in denial of claims and the cancellation of my coverage.

_____ _____

Signature of Plan Member *Signature of Plan Administrator*

DATED THIS _____day of _____20____.