Manulife

Group Benefits Plan Member Statement
Group Disability Claim Form

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form. Please note for short-term disability, there are limitations and exclusions with your contract plan. Please refer to your benefits booklet to help you understand your coverage, paying particular attention to periods for which you are not entitled to benefits and the exclusions sections. To ensure prompt handling, please ensure that you provide your signature in section 10.

Please send completed form to:
Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
E-mail: group_disability_claims@manulife.com

1 Benefit application

Please select the benefit type for which the plan member is applying.

◯ Short-term disability ◯ Long-term disability ◯ Waiver of premiums ◯ Critical illness ◯ Dismemberment

2 Plan member information

You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.

Plan sponsor name ______________________________

Plan contract number ______________ Division ______________ Certificate numbe ______________

Full name (first, middle initial, last ______________________________ ◯ Mr ◯ Mrs ◯ Ms

SIN (if benefit is taxable ______________ Date of birth (dd/mmm/yyyy) ______________ Sex ______________

Height ______________ Weight ______________ Number of dependents and ages ______________ Language preference: ◯ English ◯ French

Street address (number, street, apt) ______________________________

City ______________ Province ______________ Postal code ______________

Primary phone number ______________ Alternate phone number ______________

Work phone number ______________ Ext. ______________

By providing my personal e-mail address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by e-mail may contain personal information including, but not limited to medical, employment and financial information I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

E-mail address ______________________________

3 Direct deposit authorization

If your plan sponsor allows direct deposit, and if benefits are approved, please complete this section to consent to receiving benefits by direct deposit.

◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of your banking statement**

◯ **If depositing to a chequing account, please sign the authorization, and attach a copy of a void cheque**

Name of financial institutio ______________________________

Address of financial institution (numbe , street, suite) ______________________________

City ______________ Province ______________ Postal code ______________

Type of account: ◯ Chequing ◯ Savings

Branch or transit number (5 digits) ______________ Institution number (3 digits) ______________

Bank account number (maximum 12 digits) ______________________________

Continued on the next page

3 Direct deposit authorization (continued)

I hereby authorize Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. **I agree** that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. **I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree** that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, **I authorize** the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. **I authorize** the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate numb . The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by m

Plan member signature ______________________ Date (dd/mmm/yyyy) ____________

Plan member name (please print) ______________________

If providing a copy of a void cheque, please place it here.

4 Injury information

Occupation ______________________ Original date of hire (dd/mmm/yyyy) ____________

Is your injury/illness work related? ◯ Yes ◯ No

If *no*, was the reason you stopped working due to: ◯ Illness ◯ Injury away from work ◯ Motor vehicle accident (Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

____

____

____

Is there any legal action? ◯ Yes ◯ No If *yes*, please provide the lawyer's contact information.

Lawyer's name ______________________ Phone number ____________

Lawyer's address (number, street, suite) ______________________

5 Work information

What was the last date at work? (dd/mmm/yyyy) ____________

Was this a full day/shift? ◯ Yes ◯ No If *no*, how many hours were worked on your last day? ____________

Have you performed any other paid or volunteer work since that date? ◯ Yes ◯ No

If *yes*, please describe. Dates (dd/mmm/yyyy)

______________________ From ____________ To ____________

______________________ From ____________ To ____________

______________________ From ____________ To ____________

______________________ From ____________ To ____________

6 Illness information

When were you first treated by a physician for the current absence? (dd/mmm/yyyy ______________________

Please describe your symptoms and their frequency.

What work duties do your symptoms prevent you from performing?

Have you ever had the same or similar illness or injury? ◯ Yes ◯ No

Did it result in an absence from work? ◯ Yes ◯ No

If *yes*, please describe, include dates and treatment provided.

Do you have an expected return to work date? ◯ Yes ◯ No If *yes*, please provide the date (dd/mmm/yyyy) ______________________

7 Health care professional information

Please list all of the health care professionals you have consulted in the LAST 12 MONTHS, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name ______________________ Specialty ______________________

Address of health care professional (number, street, suite) ______________________

Phone number ______________________ Fax number ______________________

Consulted: From: (dd/mmm/yyyy) ______________________ To: (dd/mmm/yyyy) ______________________

Date of next visit (dd/mmm/yyyy) ______________________ Frequency of visits ______________________

Name ______________________ Specialty ______________________

Address of health care professional (number, street, suite) ______________________

Phone number ______________________ Fax number ______________________

Consulted: From: (dd/mmm/yyyy) ______________________ To: (dd/mmm/yyyy) ______________________

Date of next visit (dd/mmm/yyyy) ______________________ Frequency of visits ______________________

Name ______________________ Specialty ______________________

Address of health care professional (number, street, suite) ______________________

Phone number ______________________ Fax number ______________________

Consulted: From: (dd/mmm/yyyy) ______________________ To: (dd/mmm/yyyy) ______________________

Date of next visit (dd/mmm/yyyy) ______________________ Frequency of visits ______________________

8 Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and <u>submit a copy of your notice of acceptance</u>, if applicable.

Source	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Date benefit commenced? (dd/mmm/yyyy)	Amount ($)	Please describe or provide claim number, contact name and telephone number
Canada/Quebec Pension Plan							
◯ Disability ◯ Retirement	◯	◯	◯	◯			
Worker's compensation*	◯	◯	◯	◯			
Employment insurance	◯	◯	◯	◯			
Auto insurance	◯	◯	◯	◯			
Other insurance	◯	◯	◯	◯			
Income from any other source	◯	◯	◯	◯			

* Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

9 When to contact Manulife

NOTIFY MANULIFE PROMPTLY IN THE FOLLOWING CASES

<u>I acknowledge</u> I must notify Manulife immediately if:

a) my medical condition improves, even though I have not yet returned to work
b) I start work either as an employee or a self-employed person
c) I apply for benefits under any workers compensation law or plan as defined in section
d) I apply for benefits under Canada/Quebec Pension Pla
e) I receive any benefits or income from any other sourc
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disabilit
h) I am leaving the country or traveling
i) I am or will be returning to school

Plan member signature ______________________ Date (dd/mmm/yyyy) ______________

10 Agreement, authorization and certification

Please sign this authorization and send to Manulife using one of the following methods.

Via fax: (519) 579-3680 or 1-866-677-4215
Via e-mail: group_disability_claims@manulife.com
Via regular mail to: **Manulife Group Benefits**
Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2

<u>I confirm:</u>

- that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- that my claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- I am required to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, an **<u>I authorize</u>** Manulife to deduct monies from my group benefits

<u>I authorize:</u>

- Manulife and/or its service providers, its reinsurers and its service providers, and any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer and administrator of government benefits or other benefits programs to collect , use, maintain and disclose my persona information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claim(s), including independent medical assessments.
- Manulife to release information to my employer or a third party advisor of my employer for plan administration and analysis purposes only and **<u>I acknowledge</u>** that my medical information will not be provided to my employer unless my consent is explicitly obtained.
- Manulife to use my SIN for the purposes of tax reporting and identification and administration, if my SIN is used as my plan member certificate numb .

<u>I confirm:</u>

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- I understand that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found i Manulife's Privacy Policy, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or from my plan sponsor.

<u>I acknowledge:</u>

- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group life, health, or disability benefits file Access to or disclosure of my personal information will be limited to Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Plan member signature ______________________ Date (dd/mmm/yyyy) ______________

Plan member name (please print) ______________________________

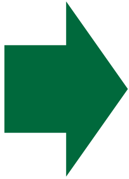
Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.

Manulife

Attending Physician Statements

- **Short Term Disability Claim**
- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
    - **Basic & Optional Life Benefit**
    - **AD&D Benefit**
    - **Survivor Benefit**

Please ensure to have your physician complete the appropriate Attending Physician Statement for submission of your disability claim.



If applying for a Short-Term Disability **(STD)** claim:	Please have your physician complete the attached Attending Physician Statement – Short Term Group Disability Claim **(pages 6 & 7)**
If applying for a Long Term Disability **(LTD)** and/or a Waiver of Premium claim:	Please have your physician complete the attached Initial Attending Physician Statement - Long Term Disability Claim **(pages 8-13)**

Please send the completed Attending Physician Statement to the address as instructed.

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN C
KITCHENER ON N2G 4Y5
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

Note: You are responsible for payment of any fees associated with completion of this form and accompanying documentation.

Manulife

Group Benefits
Attending Physician Statement
Short Term Group Disability Claim

The purpose of this Statement is to assist Manulife in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. ***PLEASE KEEP A COPY FOR YOUR RECORDS.***

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN C
Kitchener ON N2G 4Y5

Tel: 1-877-481-9169 • (519) 747-7000
Fax: 1 866 677-4215 • (519) 579-3680
Email: group_disability_claims@manulife.com

1 Plan member/employee information and consent (To be completed by patient.)

Plan member/employee name (last, first, middle initial	Home phone number	Cell phone number

Address (number, street, apt.)	City	Province	Postal code

Plan sponsor name	Plan contract number	Plan member certificate numbe

Height	Weight	Date of birth (dd/mmm/yyyy)

Last date worked (dd/mmm/yyyy)	**Date returned to work or expected return to work date** (dd/mmm/yyyy)

I hereby authorize the release of any medical information in my file to the Manufacturers Life Insurance Company ("Manulife") for the purpose of assessing my disability claim and administering the benefits plan. This medical information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it, my claim cannot be assessed. **I understand that I am responsible for any fees related to the completion of this form.**

Plan member/Employee signature ______________________ Date (dd/mmm/yyyy) ______________

2 Attending physician's statement

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the *last date worked*, complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary:

Secondary:

If childbirth provide expected or actual delivery date (dd/mmm/yyyy) ______________________

Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☐

Date of first visit pertaining to this illness (dd/mmm/yyyy	First date of work absence due to condition (dd/mmm/yyyy)

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☐ Date admitted (dd/mmm/yyyy): ______________

Name of institution: ______________________ Date discharged (dd/mmm/yyyy): ______________

If surgery was performed provide date and description of surgery.

Date (dd/mmm/yyyy): ______________ Description: ______________________

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☐ If *yes*, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other ____________________

Attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist ____________________ Specialty ____________________ Date of visit ____________________

Based on your findings and clinical observations, please describe your patient s current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

To your knowledge, is the patient following the recommended treatment program? Yes ☐ No ☐

In your opinion, is your patient competent to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life In rance Company ("Manulife") and might 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.

Attending physician (please print)	Certified specialis		Physician's stamp
Address (number, street, suite)			
City	Province	Postal code	
Telephone number	Fax number		
Signature		Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

Initial Attending Physician Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of your patient's disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

Patient authorization

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 3 before it can be submitted to Manulife.

What do we need from you?

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

Payment responsibility

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

Submitting forms

You may give the completed form to your patient or send it directly to Manulife, Group Disability Benefits, at the address indicated belo .

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN C
KITCHENER ON N2G 4Y5
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

Manulife

Group Benefits
Initial Attending Physician Statement
Group Disability Claim

1 Patient authorization

To be completed by patient.

Name (last, first, initial	Division number	Plan member certificate numbe

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of this form.**"

Patient's signature	Date (dd/mmm/yyyy)

2 Attending physician's statement

Diagnosis

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) ***If*** psychiatric disorder, provide current GAF score.

GAF score

d) ***If*** cardiac disorder, provide American Heart Association functional classification

○ Class I (No limitation) ○ Class II (Slight limitation)
○ Class III (Marked limitation) ○ Class IV (Complete limitation)

3 Clinical information

Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results in support of your patient's diagnosis and functional abilities.

a) What date did symptoms first appear/acciden happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

○ Injury ○ Work-related ○ Motor vehicle accident ○ Other (specify)
○ Illness

d) What is the date of the firs visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy	Date of latest visit (dd/mmm/yyyy)

Frequency of visits
○ Weekly ○ Bi-weekly ○ Monthly ○ Other (specify)

e) What are the patient's subjective ***symptoms***?

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity)

g) What were your initial ***clinical findings***?

h) What are your most recent ***clinical findings***?

h) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

○ Ambulatory ○ Bed confined ○ Hospital confine
○ Ambulatory with assistive devices ○ Home confine

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand ○ Left ○ Right

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)

m) ***If*** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD OS	Without corrective lenses OD OS	Date of last exam (dd/mmm/yyyy)

n) ***If*** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

◯ Recovered
◯ Improved
◯ No change
◯ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

◯ Yes ◯ No

If no, please elaborate:

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

◯ Yes ◯ No ***If no, from what date?***

Date (dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

◯ Yes ◯ No

◯ Restricted ◯ Suspended ◯ Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.

Name of attending physician (please print)

Specialty

Telephone (include area code)

Fax (include area code)

Address (number, street and apartment)

City

Province

Postal code

Signature

Date signed (dd/mmm/yyyy)

The information in this statement will be kept in a group life, health, or disability benefits file wit Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.