Manulife

Group Benefits Plan Member Statement
Group Disability Claim Form

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
Email: group_disability_claims@manulife.ca

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form. Refer to your booklet for information about your plan.

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 number _____

Full name (first, middle initial, last) _____

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 email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

Email address _____

3 Direct deposit authorization

If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.

◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement**

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

Name of financial institution _____

Address of financial institution (number, 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) 001 _____

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 to 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. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

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 ( ) _____ Ext. _____

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

City _____ Province _____ Postal code _____

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 seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, 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) ____________________

City ____________________ Province ____________________ Postal code ____________________

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) ____________________

City ____________________ Province ____________________ Postal code ____________________

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) ____________________

City ____________________ Province ____________________ Postal code ____________________

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 submit a copy of your notice of acceptance, 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

I acknowledge 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 8
d) I apply for benefits under Canada/Quebec Pension Plan
e) I receive any benefits or income from any other source
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disability
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 acknowledgement

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 email: group_disability_claims@manulife.ca
Via regular mail to: **Manulife Group Benefits**
Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2

I confirm:

- 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, and I authorize Manulife to deduct monies from my group benefits.
- that a photocopy or electronic version of this authorization shall be as valid as the original.

I authorize:

- Manulife and/or its service providers, its reinsurers and its service providers, and any person or organization who has personal information about me, including an administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal 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 use my SIN for the purposes of tax reporting and identification and administration, if my SIN is used as my plan member certificate number.
- Manulife to release information to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor for plan administration purposes.

I acknowledge:

- that my medical information will not be provided to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor unless my consent is explicitly obtained.
- that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy, available at **https://www.manulife.ca/corporate/privacy-policy.html** or from my Plan Sponsor.
- 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 and I understand that this may impact the administration of my claim and any benefit payment.

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**
    - **Critical Illness**

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 and/or a Dismemberment claim:	Please have your physician complete the attached Attending Physician Statement – Long Term Disability Claim **(pages 8-12)**
	If applying for a Critical Illness claim:	Please refer to your Plan Member secure website to print the Attending Physician's Statement corresponding to the condition.

Please send the completed Attending Physician Statement to the following address:

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
Email: group_disability_claims@manulife.ca

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 WATERLOO
Waterloo ON N2J 4C2

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

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 number
CN, CP, VIA RAIL OR OTHER RAIL ENTR. UNION		

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 medical and health information in my file to Manulife and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health 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 may not be assessed. **I understand** that I am responsible for any fees related to the completion of this form. **I agree** that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

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) - do not provide genetic test results**
- **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 ☐

Do you have concerns about the patient's ability to manage their 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 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 specialist		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.

Manulife

Group Benefits
Attending Physician Statement

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

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

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 9 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 below.

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
Email: group_disability_claims@manulife.ca

Manulife

Group Benefits
Attending Physician's Statement
Group Disability Claim

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Division number	Plan member certificate number
	613751	

"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 (excluding genetic tests) in support of your patient's diagnosis and functional abilities.

a) What date did symptoms first appear/accident 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 first 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***?

i) **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
◯ Ambulatory with assistive devices
◯ Bed confined
◯ Home confined
◯ Hospital confined

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)

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, suite)

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 with 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.

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