

Disability claims department

In order to ensure confidentiality of personal information, Manulife will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

MONTREAL

Manulife Group Benefits
 Attention: Disability Claims
 P.O. Box 400 STN Place-D'Armes
 Montreal QC H2Y 3H1

TORONTO

Manulife Group Benefits
 Attention: Disability Claims
 P.O. Box 4105 STN A
 Toronto ON M5W 2P4

CALGARY

Manulife Group Benefits
 Attention: Disability Claims
 P.O. Box 1315 STN M
 Calgary AB T2P 2L2

Instructions for the member

Please complete the "Member statement" section.

Please ensure that the Plan Sponsor completes the "Plan Sponsor statement" section.

Please ensure that your physician completes the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other conditions. As well, please provide your physician with a copy of your completed Member statement so that the physician will have your signed authorization to release information to Manulife.

Please note that any costs incurred in the completion of the "Attending physician statement" are your responsibility.

Please ensure that all of the above-mentioned forms are submitted to Manulife on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.

Please complete the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Manulife. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

Instructions for the Plan Sponsor

Please complete the "Plan Sponsor statement" section.

Instructions for the physician

Please complete the appropriate "Initial Attending Physician's statement", depending on the nature of the primary diagnosis.

DIRECT DEPOSIT AUTHORIZATION*

Plan contract and member numbers			
Plan Member Name		Social Insurance Number	
Address (number, street, apt.)	City	Province	Postal code
Name of financial institution			
Address (number, street, apt.)	City	Province	Postal code
Type of account	<input type="checkbox"/> Savings	<input type="checkbox"/> Personal chequing	<input type="checkbox"/> Current
Transit number		Bank account number	
<p>I hereby authorize the Manulife to deposit, until further notice, payments 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. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.</p>			
Plan Member's signature		Date <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	

* Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

MEMBER STATEMENT

Please note that all questions must be answered in as much detail as possible.

General information

Plan member contract n°	<input type="text"/>	Plan member certificate n°	<input type="text"/>
Title (Mr./Mrs./Ms.)	Surname	Given name(s)	Initial
Address (n°, street)		City	Province
Postal code	Telephone n°	Email	
Name of employer (and division if different)		Occupation (just prior to last day worked)	

SIN	<input type="text"/>	Date of birth	<input type="text"/>
Language :	<input type="checkbox"/> English <input type="checkbox"/> French	Gender:	<input type="checkbox"/> M <input type="checkbox"/> F
		Original date of hire	<input type="text"/>
Tax exempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state reason.	
Other current employer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please name	

Claim information

Was the reason you stopped working due to:

Illness Injury away from work Motor vehicle accident (not while working)¹ Occupational illness or work accident

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

<input type="text"/>
<input type="text"/>

What was the last day you worked?	<input type="text"/>	Were you performing:	<input type="checkbox"/> Your regular duties <input type="checkbox"/> Modified duties
Was this a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, how many hours did you work on your last day?	<input type="text"/>	

What was the date you were first unable to work?	<input type="text"/>
When did you first notice these symptoms?	<input type="text"/>
When were you first treated by a physician?	<input type="text"/>

Please describe all of your symptoms, including frequency and severity.
<input type="text"/>
<input type="text"/>

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

If Yes, please provide the dates and name(s) of physicians who treated you at the time.
<input type="text"/>
<input type="text"/>

Please describe the major duties of your occupation.
<input type="text"/>
<input type="text"/>

MEMBER STATEMENT (CONTINUED)

Please describe why you are unable to perform the duties of your occupation.

Do you have an expected date of return to work? Yes No If Yes, please provide the date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

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	
Complete address	Telephone n°	Fax n°

Consulted from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name	Specialty	
Complete address	Telephone n°	Fax n°

Consulted from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name	Specialty	
Complete address	Telephone n°	Fax n°

Consulted from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

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?		Are you receiving payment?			Monthly amount	Claim no., contact name, telephone no.
	Yes	No	Yes	No	Pending		
Worker's Comp / CSST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Canada Pension Plan – Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Canada Pension Plan – Retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Québec Pension Plan (QPP) – Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Québec Pension Plan (QPP) – Retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Employment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Auto Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Insurer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Member authorization and declaration

I certify 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. I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I agree 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 such monies from my group benefits. Manulife will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.

I authorize 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, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency, to release my personal information to Manulife and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize Manulife, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my plan member certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I acknowledge 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 and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

I understand 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 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; 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.

Plan Member's Signature

Date

Authorization: e-mail consent

By providing my personal e-mail address, I am authorizing Manulife to use the e-mail address provided as an additional means of communication with me 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 secured means of communication.

Plan Member's Signature

Date