Manulife

Disability claim form

Initial assessment

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 ☐ Savings ☐ Personal chequing ☐ Current | Transit number | Bank account number

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.

Plan Member's signature | Date D D M M Y Y Y 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 nº

Plan member certificate nº

Title (Mr./Mrs./Ms.) | Surname | Given name(s) | Initial

Address (nº, street) | City | Province

Postal code | Telephone nº | Email

Name of employer (and division if different) | Occupation (just prior to last day worked)

SIN

Date of birth D D M M Y Y Y Y

Language : ☐ English ☐ French

Gender: ☐ M ☐ F

Original date of hire D D M M Y Y Y Y

Tax exempt ☐ Yes ☐ No

If yes, please state reason.

Other current employer ☐ Yes ☐ 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.

What was the last day you worked? D D M M Y Y Y Y

Were you performing: ☐ Your regular duties ☐ Modified duties

Was this a full day? ☐ Yes ☐ No If No, how many hours did you work on your last day?

What was the date you were first unable to work? D D M M Y Y Y Y

When did you first notice these symptoms? D D M M Y Y Y Y

When were you first treated by a physician? D D M M Y Y Y Y

Please describe all of your symptoms, including frequency and severity.

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.

Please describe the major duties of your occupation.

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 nº Fax nº

Consulted from D D M M Y Y Y Y to D D M M Y Y Y Y

Name Specialty

Complete address Telephone nº Fax nº

Consulted from D D M M Y Y Y Y to D D M M Y Y Y Y

Name Specialty

Complete address Telephone nº Fax nº

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	☐	☐	☐	☐	☐		
Canada Pension Plan – Disability	☐	☐	☐	☐	☐		
Canada Pension Plan – Retirement	☐	☐	☐	☐	☐		
Québec Pension Plan (QPP) – Disability	☐	☐	☐	☐	☐		
Québec Pension Plan (QPP) – Retirement	☐	☐	☐	☐	☐		
Employment Insurance	☐	☐	☐	☐	☐		
Auto Insurance	☐	☐	☐	☐	☐		
Other Insurer	☐	☐	☐	☐	☐		

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

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Calgary AB T2P 2L2

PLAN SPONSOR STATEMENT

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

Plan Sponsor information

Name of Plan Sponsor (Employer/Union/Association) | Name of subsidiary or division (if different)

Complete address

Member information

Plan contract number | Division nº | Class nº | Plan member certificate nº

Surname | Given name(s) | Initial

Social insurance number | Permanent employee? ☐ Yes ☐ No

Nature of request for benefits: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Waiver of premiums ☐ Dismemberment

Was the employee actively at work when the absence began / loss occurred? ☐ Yes ☐ No

If Yes, please provide the date on which this member was first covered under this plan contract number: D D M M Y Y Y Y

If No, please comment.

What was the member's date of hire? D D M M Y Y Y Y | last date of work? D D M M Y Y Y Y

If already back at work, what was the start date? ☐ Part-time D D M M Y Y Y Y ☐ Full-time D D M M Y Y Y Y

What was the member's main reason for absence:

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

Please indicate the hours of work in a normal week, if shift work, please provide work schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What was the member's gross weekly salary as of his/her last day of work? | Was the member ☐ Salaried ☐ Hourly

Tax information

Please complete only if benefit is taxable.

TD1 | TP1 | Percentage to be deducted % | TD1 TP1 Member's province of residence for income tax purposes

Did the member receive any income during the disability period? ☐ Yes ☐ No

If Yes, please select one of the following: ☐ Vacation ☐ Maternity leave ☐ Employment insurance ☐ Sick days ☐ Statutory holidays ☐ Other

If Other, please comment.

PLAN SPONSOR STATEMENT (CONTINUED)

Amount $ From D D M M Y Y Y Y to D D M M Y Y Y Y

Has the member submitted a claim to the following government bodies?

☐ WSIB / WCB / CSST ☐ EI ☐ CPP ☐ QPP (RRQ) ☐ Provincial automobile insurance board

Occupational information

What was the member's regular occupation immediately prior to his/her stopping work?

Were the member's duties modified from his/her regular occupation? ☐ Yes ☐ No

Please describe this employee's regular occupation (or attach a copy of the company's job description) as well as any modifications, if any.

The following physical demands analysis of the member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

1. at any one time without a break (approximately) **and**;
2. in total throughout the day (approximately)

Physical demands analysis			1.	2.
Sitting				
Standing				
Driving				
Climbing up and down the stairs				
Lifting	☐ 0 - 10 pounds ☐ 20 - 50 pounds	☐ 10 - 20 pounds ☐ 50 pounds +		
with lifting device?	☐ Yes	☐ No		
Pushing/Pulling	☐ 0 - 10 pounds ☐ 20 - 50 pounds	☐ 10 - 20 pounds ☐ 50 pounds +		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.)

Does the participant wear personal protective equipment (i.e. safety glasses/footwear, respiratory protection, ear protection, etc.)? ☐ Yes ☐ No

If Yes, please describe.

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature Title

Telephone Date D D M M Y Y Y Y

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 plan member 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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Calgary AB T2P 2L2

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS)

Patient authorization

Name (last, first, initial) | Plan contract number | Plan member certificate number

Height | Weight | Date of birth D D M M Y Y Y Y

"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 the form**."

Patient's signature | Date D D M M Y Y Y Y

Diagnosis

What is the primary diagnosis?

When did the symptoms first appear or date accident occurred? D D M M Y Y Y Y

What was the date of the patient's first visit for his/her current condition? D D M M Y Y Y Y

What was the date of the patient's first visit during the present period of absence from work? D D M M Y Y Y Y

If the patient has a cardiac condition, what is his/her curent functional capacity based on the American Heart Association classifications:

☐ Yes Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Severe Limitation)

What is the patient's blood pressure? Current | Previous | Date D D M M Y Y Y Y

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed? ☐ Yes ☐ No
If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? ☐ Yes ☐ No

If Yes, please elaborate.

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)

What are the patient's current limitations **(things that he/she cannot do)**? Please be specific.

What are the patient's current restrictions **(things that he/she should not do)**? Please be specific.

Is your patient competent to manage his/her own financial affairs? ☐ Yes ☐ No

Please indicate the date the patient stopped working based on your recommendation. D D M M Y Y Y Y

If a potential return to work date has been discussed, please provide the date. D D M M Y Y Y Y

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If Yes, please provide dates and describe.

Is the patient's condition due to injury or sickness arising out of his/her employment? ☐ Yes ☐ No

If Yes, please elaborate.

If the patient was/is pregnant, please indicate the date or expected date of confinement. D D M M Y Y Y Y

Treatment

Frequency of patient visits: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

If Other, please describe.

Please detail the patient's past and present treatment (e.g. date and type of surgery) as well as response to treatment.

Has the patient been hospitalized? ☐ Yes ☐ No

If Yes, please provide the name of the hospital(s) and the dates of confinement.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

If this patient was referred to you, please provide the name of the referring physician.

If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.

Name (please print)	Specialty
Complete address	
Telephone nº	Fax nº

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Signature

Date D D M M Y Y Y Y

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INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS)

Patient authorization

Name (last, first, initial)	Plan contract number	Plan member certificate number

Height	Weight	Date of birth D D M M Y Y Y Y

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Patient's signature	Date D D M M Y Y Y Y

Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I

II

III

IV

V

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work? ☐ Yes ☐ No

If Yes, please elaborate.

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

When did symptoms first appear? Date D D M M Y Y Y Y

Please describe the patient's initial reason for seeking treatment.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)

Was there a precipitating event? ☐ Yes ☐ No

If Yes, please elaborate.

What was the date of the patient's first visit for his/her current condition? D D M M Y Y Y Y

What was the date of the patient's first visit during the present period of absence from work? D D M M Y Y Y Y

Is your patient's condition caused directly or indirectly by his/her employment? ☐ Yes ☐ No

If Yes, please elaborate.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should** not do)? Please be specific.

Is your patient competent to manage his/her own financial affairs? ☐ Yes ☐ No

Please indicate the date the patient stopped working based on your recommendation. D D M M Y Y Y Y

If a potential return to work date has been discussed, please provide the date. D D M M Y Y Y Y

Treatment

Frequency of patient visits:

☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

If Other, please describe.

Please detail the patient's past and present treatment (including psychotherapy) response to treatment, and compliance.

Has the patient been hospitalized? ☐ Yes ☐ No

If Yes, please provide the name of the hospital(s) and the dates of confinement.

INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y
		D D M M Y Y Y Y

Functional capacities evaluation

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

None: No impairment in this area after basis.
Mild: Suspected impairment of slight importance which does not affect functional ability.
Moderate: Impairment affects but does not preclude ability to function**.**
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
Ability to relate to friends and family members	☐	☐	☐	☐	☐
Ability to attend to personal care (bathing, cooking, etc.)	☐	☐	☐	☐	☐
Ability to carry out household chores	☐	☐	☐	☐	☐
Ability to relate to co-workers and supervisors	☐	☐	☐	☐	☐
Perform work where contact with others will be minimal	☐	☐	☐	☐	☐
Understand, carry out, and remember instructions	☐	☐	☐	☐	☐
Perform tasks involving minimal intellectual effort or repetitive tasks	☐	☐	☐	☐	☐
Perform varied tasks	☐	☐	☐	☐	☐
Ability to follow a regular work schedule	☐	☐	☐	☐	☐
Make independent judgements	☐	☐	☐	☐	☐
Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	☐	☐	☐	☐	☐
Supervise or manage others	☐	☐	☐	☐	☐

Name (please print)	Specialty
Complete address	
Telephone nº	Fax nº

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Signature	Date D D M M Y Y Y Y

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