Manulife Financial

# Group Benefits
# Plan Sponsor Statement
## Short Term Group Disability Claim

- To be completed by the plan sponsor.
- Please print clearly and answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- Provide the plan member with a Member Statement form and an Attending Physician Statement form for the family physician or attending specialist. Ask the plan member to complete the "Plan member/employee information and consent" section at the top of the Attending Physician Statement form on page 6 before they take it to their physician.

**Return completed form to: Manulife Financial Group Benefits**
**Attention: Disability Claims**
**PO BOX 4606 STN A, TORONTO ON M5W 4Z2**
**Tel: 1-800-465-2076 • (416) 687-5049 Fax: (416) 687-5132 • (416) 687-5211**

### 1 Plan sponsor information

Plan contract number | Division number | Company name

Address (number, street, suite) | City | Province | Postal code

Contact name | Title | Telephone number ( ) | Fax number ( )

Plan sponsor contribution to premiums
STD _____ % ◯ Non-taxable

### 2 Plan member identification

Name (last, first, initial) ◯ Male ◯ Female

Plan member certificate number | Division number | Class | Date of birth (dd/mmm/yyyy)

### 3 Plan member information

Date of hire (dd/mmm/yyyy) | Date insured (dd/mmm/yyyy)

Plan member's job title

Plan member's work hours?
◯ Full-time HRS/WK _____ ◯ Part-time HRS/WK _____ ◯ Shift work SHIFTS/WK _____ ◯ Other HRS/WK _____

**If the plan member works non-standard shifts/cycles, please describe or attach a copy of the shift schedule.**

Date last worked (dd/mmm/yyyy) | Number of hours worked that day | Next scheduled work day/shift prior to disability

Reason plan member stopped working
◯ Illness ◯ Injury ◯ On layoff ◯ Leave of absence
◯ Dismissed ◯ Resigned ◯ Strike ◯ Other _____

Has the plan member returned to work? ◯ Yes ◯ No

*If yes, please provide date returned to work.* (dd/mmm/yyyy)

*If no, please provide expected return date.* (dd/mmm/yyyy)

Has coverage terminated? ◯ Yes ◯ No *If yes, please state when and reason why.*

Date coverage terminated (dd/mmm/yyyy) | Reason for termination of coverage

### 4 Plan member's earnings and benefit information

**It is important all sources of income be reported immediately. It is possible that these may impact potential benefit payment.**

*Please provide the following information, **OR** a copy of the current payslip.*

Base salary/wage when member was last at work
$

Commissions (if applicable) *(Please provide T4A documentation as per policy provisions)*
$

Other income (if applicable) *(Overtime, bonus, shift differential as per policy provisions)*
$

Payment schedule
◯ Hourly ◯ Weekly ◯ Bi-weekly
◯ Semi-monthly ◯ Monthly ◯ Annually

Date of last salary change (dd/mmm/yyyy)

## 5 Tax information

Please complete only if benefit is taxable.

*Please provide the following information, **OR** a completed TD1 or TP1 form.*

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

## 6 Additional earnings

Please indicate if any of the following have been paid.

| INCOME/ BENEFIT | PAID/ PAYABLE | | WEEKLY | BI-WEEKLY | MONTHLY | PAID FROM (dd/mmm/yyyy) | PAID TO (dd/mmm/yyyy) | AMOUNT |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | | | | | | |
| Salary continuance | ◯ | ◯ | ◯ | ◯ | ◯ | | | $ |
| Sick leave | ◯ | ◯ | ◯ | ◯ | ◯ | | | $ |
| Vacation pay | ◯ | ◯ | ◯ | ◯ | ◯ | | | $ |
| Severance | ◯ | ◯ | ◯ | ◯ | ◯ | | | $ |
| Other | ◯ | ◯ | ◯ | ◯ | ◯ | | | $ |

## 7 Workers' compensation information

Please provide copy of information received from any type of workers' compensation board.

Is the current condition due to a work related accident or illness? ◯ Yes ◯ No

*If yes, has a claim been filed with any type of workers' compensation board?* ◯ Yes ◯ No

*If no, please provide reason*

Please provide a copy of the Accident/Illness report and:

| Workers' compensation board contact name* | Telephone number | Fax number |
|---|---|---|
| | ( ) | ( ) |

| Claim number | Date benefit commenced (dd/mmm/yyyy) | Date benefit ceased (dd/mmm/yyyy) |
|---|---|---|
| | | |

What is the current status of the application? ◯ Pending ◯ Approved ◯ Declined

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

## 8 Work information

What are the primary duties of the plan member's job? (e.g. operate machinery, supervising responsibilities, customer service duties, maintain mechanical equipment, use a computer, etc.)

## 9 Job requirements

In this section we are gathering information about the plan member's specific physical job tasks. If you have a physical demands analysis, please provide it, **OR** complete the following section as applicable.

| PHYSICAL DEMANDS OF JOB | ACTIVITY | MAXIMUM WEIGHT (lbs.) | FREQUENCY | | |
|---|---|---|---|---|---|
| | Lifting | | ◯ Infrequent | ◯ Frequent | ◯ Constant |
| | Carrying | | ◯ Infrequent | ◯ Frequent | ◯ Constant |
| | Sitting | | ◯ Infrequent | ◯ Frequent | ◯ Constant |
| | Standing | | ◯ Infrequent | ◯ Frequent | ◯ Constant |
| | Walking | | ◯ Infrequent | ◯ Frequent | ◯ Constant |

## 10 Modified work

Before the plan member stopped working did the illness or injury cause a change in job duties/hours worked or performance? *If yes, please explain.*

## 11 Declaration

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

| Authorized signature | Title |
|---|---|
| | |

| Telephone number | Date (dd/mmm/yyyy) |
|---|---|
| ( ) | |

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial 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.

Manulife Financial

# Group Benefits
# Request for Direct Bank Deposit

**Return completed form to: Manulife Financial Group Benefits**
**Attention: Disability Claims**
**PO BOX 4606 STN A, TORONTO ON M5W 4Z2**
**Tel: 1-800-465-2076 • (416) 687-5049 Fax: (416) 687-5132 • (416) 687-5211**

## Direct Bank Deposit

**Please complete this section in the event that benefits are approved.**

Please attach a sample of a cheque for the account. *(Mark it void)*

**IN THE EVENT BENEFITS ARE APPROVED,** would you consent to your plan member receiving benefits directly in their bank account? ◯ Yes ◯ No

*If you have selected yes, please have the following information completed by your plan member.*

| Plan contract numbers (include your plan member certificate number if this is a group policy) | | | |
|---|---|---|---|
| | | | |
| Name of person(s) receiving payments | | | Social Insurance Number |
| | | | |
| Address (number, street, apt.) | City | Province | Postal code |
| | | | |
| Name of financial institution | | | |
| | | | |
| Address (number, street, suite) | City | Province | Postal code |
| | | | |
| Type of account<br>◯ Savings ◯ Personal chequing ◯ Current | Transit number | Bank account number | |
| | | | |

I hereby authorize the Manufacturers Life Insurance Company ("Manulife Financial") to deposit, until further notice, payments due to me from the above policy, into my bank account. I agree that Manulife Financial 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 Financial 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.

| Authorized signature | Date (dd/mmm/yyyy) |
|---|---|
| | |

Please attach your cheque sample marked "Void" here.

Manulife Financial

# Group Benefits
# Member Statement
## Short Term Group Disability Claim

- To be completed by the employee.
- Please print clearly and answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- **You are responsible for any fees your doctor charges for completion of the Attending Physician Statement form and photocopies of file documentation.**

**Return completed form to:** **Manulife Financial Group Benefits**
**Attention: Disability Claims**
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**Tel: 1-800-465-2076 • (416) 687-5049 Fax: (416) 687-5132 • (416) 687-5211**

## 1 Plan member information

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

| | | | |
|---|---|---|---|
| Plan contract number | Plan member certificate number | | |
| Plan sponsor's name | | Job title | |
| Plan member's full name (last, first, initial) | ◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs. | Date of birth (dd/mmm/yyyy) | |
| Social Insurance Number | Preferred language ◯ English ◯ French | Height | Weight |
| Full address (number, street and apt.) | | | |
| City | Province | Postal code | |
| Telephone number ( ) | Fax number ( ) | Number of dependants and ages | |

## 2 Claim information

Last day worked (dd/mmm/yyyy)

Is your condition due to an accident? ◯ Yes ◯ No *If no, please go to item 3.*

What kind of accident?

◯ Motor vehicle accident ◯ Work related ◯ Other

| | | |
|---|---|---|
| Name of Motor Vehicle Accident Insurance carrier | Contact person | Contact's telephone number ( ) |
| Describe how and when injury occurred | | Date of accident (dd/mmm/yyyy) |
| | | Time of accident ◯ a.m. ◯ p.m. |

Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide the following information:*

| | |
|---|---|
| Lawyer's name | Telephone number ( ) |

Was the occurrence investigated by police? ◯ Yes ◯ No

*If yes, please provide a copy of the police report.*

## 3 Medical information

List all doctors consulted for your present condition.

| | | | |
|---|---|---|---|
| **Name of Doctor/Specialist** | | *Approximately when did you first seek medical attention for this condition?* | Date (dd/mmm/yyyy) |
| Address of doctor (number, street, suite) | | | Date of next visit (dd/mmm/yyyy) |
| City | | Province | Frequency of visits |
| Postal code | Telephone number ( ) | Type of practitioner | |

## 3 Medical information *(continued)*

List all doctors consulted for your present condition.

| Name of Doctor/Specialist | *Approximately when did you first seek medical attention for this condition?* | Date (dd/mmm/yyyy) |
|---|---|---|
| Address of doctor (number, street, suite) | | Date of next visit (dd/mmm/yyyy) |
| City | Province | Frequency of visits |
| Postal code | Telephone number ( ) | Type of practitioner |

## 4 Work information

What are your job duties?

When do you expect to return to your job? Date (dd/mmm/yyyy)

## 5 Income/benefit information

Have you applied for or are you receiving any of the following Income/benefits. ***If so, please provide copies of pay slips and/or award letters, including decline letters.***

**It is important that all sources of income be reported immediately. It is possible that these may impact potential benefit payment.**

| INCOME/ BENEFIT | REFERENCE OR CLAIM NO. | BENEFIT DATES (dd/mmm/yyyy) START | BENEFIT DATES (dd/mmm/yyyy) END | FREQUENCY WEEKLY | FREQUENCY BI-WEEKLY | FREQUENCY MONTHLY | FREQUENCY LUMP SUM | AMOUNT |
|---|---|---|---|---|---|---|---|---|
| Any type of workers' compensation board* | | | | ○ | ○ | ○ | ○ | $ |
| Motor Vehicle Insurance | | | | ○ | ○ | ○ | ○ | $ |
| Employment Insurance | | | | ○ | ○ | ○ | ○ | $ |
| Other | | | | ○ | ○ | ○ | ○ | $ |

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

## 6 Certification, agreement and authorization

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 Financial in accordance with the provisions of the group benefits plan with Manulife Financial, and I authorize Manulife Financial to deduct such monies from my group benefits. Manulife Financial 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 Financial 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 Financial, 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 certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

I understand that information relating to Manulife Financial's Privacy Policy, which includes information on how and why Manulife Financial collects, uses, maintains and discloses my personal information, is available upon request; on Manulife Financial's Web site: www.manulife.ca, or through my Plan Sponsor.

I understand that any personal information provided to or collected by Manulife Financial 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 Financial 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 signature | Date signed (dd/mmm/yyyy) |
|---|---|
| | |

Manulife Financial

Canadian Life and Health Insurance Association Inc. | Association canadienne des compagnies d'assurances de personnes inc.

# Group Benefits
# Attending Physician's Statement
## Short Term Group Disability Claim

*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.***

**Return completed form to:** **Manulife Financial Group Benefits**
**Attention: Disability Claims**
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**Tel: 1-800-465-2076 • (416) 687-5049 Fax: (416) 687-5132 • (416) 687-5211**

### 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 |
|---|---|---|
| | | |

| 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 Financial") 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

STOP

**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 Insurance Company ("Manulife Financial") 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.**