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 number _____

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 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) _____

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 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 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 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 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

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.

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 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 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 release information to my employer or a third party advisor of my employer for plan administration and analysis purposes only and **I acknowledge** 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 number.

I confirm:

- 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 in Manulife's Privacy Policy, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or from my plan sponsor.

I acknowledge:

- 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.