Manulife

Group Benefits Sponsor Statement
Group Disability Claim

- Please ensure to answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- This notification must be sent to Manulife without delay.

Please send this 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 sponsor information

Plan contract number ______________ Plan sponsor name ______________

Street address (number, street, suite) ______________

City ______________ Province ______________ Postal code ______________

Plan sponsor contact name ______________ Job title ______________

Phone number ______________ Fax ______________ E-mail ______________

Health centre contact and return work contact
If different from above, please indicate the person in the health centre involved in disability absences.

Name ______________ Job title ______________

Phone number ______________ E-mail ______________

If different from above, please indicate the person we should contact to facilitate a return to work once this employee's abilities and limitations are known.

Name ______________ Job title ______________

Phone number ______________ E-mail ______________

3 Plan member identification and work information

Full name (first, middle initial, last) ______________

Date of birth (dd/mmm/yyyy) ______________

Certificate number ______________ Primary phone number ______________ Alternate phone number ______________

Class ______________ Division ______________ Job title ______________

Permanent employee ◯ Yes ◯ No Date of hire (dd/mmm/yyyy) ______________

Date for which the plan member was first covered under this plan. Date (dd/mmm/yyyy) ______________

Has there been any interruption in the plan member's coverage? ◯ Yes ◯ No

Please indicate the **HOURS** of work in a normal week.

Is this shift work? ◯ Yes ◯ No

If *yes*, please indicate the work schedule or attach a copy of the work schedule.

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours of work each day							

Provide details if plan member's shift schedule is varied or rotational: ______________

Is the member required to work night shift? ◯ Yes ◯ No

Plan member's gross salary as of the last day of work $ ______________ ◯ Per week ◯ Per month

Was the plan member: ◯ Salaried ◯ Hourly

What was the last date at work? Date (dd/mmm/yyyy) ______________

3 Plan member identification and work information (continued)

Was this a full day/shift? ◯ Yes ◯ No

If *no*, how many hours were worked? _______ Is the absence work related? ◯ Yes ◯ No

What was the plan member's first missed day of work? Date (dd/mmm/yyyy) ______________________

Has the plan member returned to work? ◯ Yes ◯ No If *yes*, when? Date (dd/mmm/yyyy) ______________________

Did the plan member return to: ◯ Regular duties ◯ Modified duties

Tax Information - Please complete only if the benefit is taxable

TD1 code ____________ TP1 code ____________ Plan member's province of residence for income tax purposes ______________________

Is employment income tax exempt according to terms of Indian Act and Income Tax Act? ◯ Yes ◯ No If *yes*, please provide copy of TD1-IN.

Please indicate if any of the following have been paid (or are payable) since date plan member last worked

	Amount	Dates (dd/mmm/yyyy)			
Salary continuance	______________	From	______________	To	______________
Vacation	______________	From	______________	To	______________
Sick Leave	______________	From	______________	To	______________
Severance	______________	From	______________	To	______________
Employment Insurance benefits	______________	From	______________	To	______________
Other * ______________ (please indicate the source)	______________	From	______________	To	______________

*E.g. Short-term disability benefits, commissions or bonuses, retirement pension. If more space is needed, please use a separate sheet of paper.

4 Life coverage

To be completed for self-administered groups applying for waiver of premium or please provide a copy of the Enrolment Application.

Group Life Benefit

Plan contract number ________________ Division ______________ Effective date of coverage (dd/mmm/yyyy) ______________________

Annual salary $________________ Date of last increase (dd/mmm/yyyy) ______________________

Life coverage when last actively at work ◯ Terminated ◯ Active ◯ Suspended

Amount of Life coverage

◯ Basic $__________ ◯ Spousal $__________ ◯ Dependent Children $__________

◯ Optional $__________ ◯ Optional Spousal $__________ ◯ Other ____________ $__________
(specify)

Group Accidental Death and Dismemberment Benefit (AD & D)

Plan contract number ________________ Division ______________ Effective date of coverage (dd/mmm/yyyy) ______________________

Amount of AD & D coverage

◯ Basic $__________ ◯ Optional $__________ ◯ Spousal $__________ ◯ Optional Spousal $__________

Group Survivor Income Benefit

Plan contract number ________________ Division ______________ Effective date of coverage (dd/mmm/yyyy) ______________________

Monthly survivor benefit amount $__________ Type of coverage ◯ Spousal ◯ Spousal and children ◯ Other (specify) ______________

Critical Illness Benefit

Plan contract number ________________ Division ______________ Effective date of coverage (dd/mmm/yyyy) ______________________

Amount of Critical Illness Benefit

◯ Plan member basic $__________ ◯ Plan member optional $__________ ◯ Spousal $__________ ◯ Child $__________

5 Declaration

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

Name ____ Title ______________________

Signature ____ Date (dd/mmm/yyyy) ______________________

Please ensure section 6 is completed by the plan member's supervisor.

6 Occupational information

This section may be separated from the rest of the form if necessary. Please attach a physical demands analysis if available.

Completed by:

Name and title ____________________ Date completed (dd/mmm/yyyy) ____________

What was the plan member's occupation immediately prior to the plan member stopping work? ____________________

Were the plan member's duties and/or hours modified from their regular occupation? ◯ Yes ◯ No If so, when? (dd/mmm/yyyy) ____________

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

7 Occupational demands

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the frequency for which the following activities are regularly performed:

PHYSICAL ACTIVITIES

Activity	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Walking	◯	◯	◯	◯
Sitting	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Driving / Operating machinery	◯	◯	◯	◯
Climbing up and down the stairs	◯	◯	◯	◯

Does the employee's occupation require repetitive movements? ◯ Yes ◯ No

Lifting	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	◯	◯	◯	◯
11-20 lb.	◯	◯	◯	◯
21-50 lb.	◯	◯	◯	◯
51-100 lb.	◯	◯	◯	◯
100+ lb.	◯	◯	◯	◯

Pushing/ Pulling	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	◯	◯	◯	◯
11-20 lb.	◯	◯	◯	◯
21-50 lb.	◯	◯	◯	◯
51-100 lb.	◯	◯	◯	◯
100+ lb.	◯	◯	◯	◯

Does the plan member use a lifting device? ◯ Yes ◯ No

COGNITIVE ACTIVITIES

Activity	Definition	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Understanding and memory	Understanding and remembering instructions	◯	◯	◯	◯
Sustained concentration	Maintaining attention and concentration for extended periods	◯	◯	◯	◯
Social interaction	Interaction with co-workers and/or the general public	◯	◯	◯	◯
Adaptation and multitasking	Response to frequent changes, juggle tasks and prioritizes	◯	◯	◯	◯
Meeting deadlines	The work involves time pressure and deadlines	◯	◯	◯	◯
Responsibility and accountability	Errors in judgement or attention can have significant consequences	◯	◯	◯	◯

8 Declaration

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

Name ____________________ Title ____________

Signature ____________________ Date (dd/mmm/yyyy) ____________

Please note: 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.