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's Statement form for the family physician or attending specialist. Ask the plan member to complete the "Patient authorization" section at the top of the Attending Physician's 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 1030 STN CENTRAL, HALIFAX NS B3J 2X5
Tel: 1-800-565-0627 • (902) 453-4300 Fax: (902) 429-7292

1 Plan sponsor

Plan contract number	Division number	Company name	
Address (number, street)	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 ◯ Annual

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 1030 STN CENTRAL, HALIFAX NS B3J 2X5
Tel: 1-800-565-0627 • (902) 453-4300 Fax: (902) 429-7292

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)	City	Province	Postal code

Name of financial institution

Address (number, street)	City	Province	Postal code

Type of account	Transit number	Bank account number
◯ Savings ◯ Personal chequing ◯ Current		

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's Statement form and photocopies of file documentation.**

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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.	Birthdate (dd/mmm/yyyy)	
Social Insurance Number	Preferred language: ◯ English ◯ French	Height	Weight
Full address (number, street and apartment, P.O. Box number)			
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?	(dd/mmm/yyyy)
Address of doctor (number and 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? (dd/mmm/yyyy)
Address of doctor (number and 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 / END	FREQUENCY: WEEKLY	BI-WEEKLY	MONTHLY	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's signature	Date signed (dd/mmm/yyyy)

Manulife Financial

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

The purpose of this Statement is to assist Manulife Financial in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife Financial to make this decision. 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.***

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1 Patient authorization

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

Address

Date of birth (dd/mmm/yyyy) | Height | Weight

"I hereby authorize the release to Manulife Financial 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 this form.**"

Patient's signature | Date (dd/mmm/yyyy)

2 Attending Physician's Statement

A. History

When did symptoms first appear or accident happen? — Date (dd/mmm/yyyy)

What date did patient cease work because of illness/injury? — Date (dd/mmm/yyyy)

Has patient ever had the same or a similar condition? — ◯ Yes ◯ No

If "Yes", state when and describe.

Is condition due to injury or sickness arising out of patient's employment? — ◯ Yes ◯ No ◯ Unknown

Is a claim being submitted to any type of worker's compensation board? — ◯ Yes ◯ No

Has the patient been confined in a hospital?
If available please include admission and discharge summaries. — ◯ Yes ◯ No

If "Yes"

Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)

Name, specialty and address of other treating physician(s)

Name	Specialty	Address

B. Diagnosis

a) Primary

b) List any additional conditions or complications

c) Subjective symptoms

d) **Please include copies of the following documentation in support of the stated diagnosis: consultation notes, test/investigation report(s), psychological testing report(s), operative report(s), hospital admission and discharge summary(ies).**

If your patient is/was pregnant, please provide the expected/actual delivery date. (dd/mmm/yyyy)

3 Treatment

Frequency of visits

- Weekly
- Monthly
- Other (specify)

Date of first visit (dd/mmm/yyyy)

Date of last visit (dd/mmm/yyyy)

Date of all visits between first and last visit (dd/mmm/yyyy)

Nature of treatment (including surgery, physiotherapy, psychotherapy and medications prescribed and dosages)

When do you expect a significant change in the functional limitation affecting your patient?

To your knowledge is patient following the recommended treatment program? ◯ Yes ◯ No

Is there potential for future improvement? ◯ Yes ◯ No

If no, please comment.

Have you recommended that your patient's driver's licence be revoked? ◯ Yes ◯ No

4 Physical impairment

Does your patient have a physical impairment?

◯ Yes ◯ No

If yes, please complete this section.

Based on objective findings please describe your patient's abilities in the following areas:

lifting	(max. weight/frequency)	sitting	(how long/frequency)
		standing	(how long/frequency)
carrying	(max. weight/distance)	walking	(distance/frequency)

Remarks

5 Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

◯ Yes ◯ No

If yes, please complete this section.

Indicate if patient has cognitive/mental restrictions in the following areas.

	None	Mild	Moderate	Severe
◯ concentration				
◯ analytical reasoning				
◯ learning new material				
◯ comprehension				
◯ social interaction				

What is the DSM IV diagnosis? (Axis 1)

What is the current GAF?

Remarks

Please provide copies of consultation reports and your most recent mental status test results and list all abnormal findings supporting the above restrictions.

Competency

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ◯ Yes ◯ No

6 Cardiac (if applicable)

a) Functional capacity (American Heart Association)

- ◯ Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.
- ◯ Class 2 - Greater than ordinary physical activity results in symptoms.
- ◯ Class 3 - Ordinary physical activity results in symptoms.
- ◯ Class 4 - Symptoms at rest, and worse with any physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

7 Physician's authorization

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 patient 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.

Attending physician (please print)

Certified specialist

Telephone number (include area code)
( )

Address (number, street, city, province, postal code)

Fax number (include area code)
( )

Signature

Date signed (dd/mmm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM, IN THE PROVINCES WHERE APPLICABLE.