Manulife Financial

Group Benefits
Plan Member/Dependant Statement
Accidental Dismemberment Claim

INSTRUCTIONS
If a dependant claim is made, please fill out all sections relevant to the dependant.
Plan sponsor statement - To be completed by plan administrator (page 1).
Plan member statement - To be completed by plan member (page 2).
Attending physician's statement - To be completed by attending physician (page 3).

- ***Please print all answers.***
- ***To avoid delay in the processing of the claim, please ensure that every question is answered.***
- ***The plan member is responsible for the completion of this form without expense to Manulife Financial.***

1 Plan sponsor statement for plan member accidental dismemberment

Plan number(s)	Account/Division number	Certificate number

Plan sponsor's name	Employer's name (if different from plan sponsor)

Plan member's name (last, first, middle initial)	Date of birth (dd/mmm/yyyy)	Occupation of plan member

Status of plan member ◯ Full time ◯ Part time	Date of employment (dd/mmm/yyyy)	Date last worked (dd/mmm/yyyy)	Salary effective date (dd/mmm/yyyy)

Regular no.of hrs. worked/ week	Amount of insurance	Current salary	
	$	$	◯ Annually ◯ Monthly ◯ Semi-monthly ◯ Bi-weekly ◯ Weekly ◯ Hourly

Is the injury work related? ◯ Yes ◯ No

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

* 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).

Was plan member:
◯ Retired ◯ Temporary layoff ◯ Disabled ◯ Leave of absence

Date of termination (if applicable) (dd/mmm/yyyy)

If plan member was disabled, was any claim for disability benefits filed during this period? If "Yes", please provide claim number and name of carrier. ◯ Yes ◯ No

Claim number	Name of carrier

According to your records, on the date of the accident had the plan member/ dependant fully satisfied the eligibility requirements for dismemberment insurance under this plan? ◯ Yes ◯ No

Dependant information

(To be completed if a dependant claim is made.)

Dependant's name (last, first, middle initial)	Relationship to plan member	Date of accident (dd/mmm/yyyy)

Amount of dependant insurance
$

Is dependant spouse insured at non-smoker rates? ◯ Yes ◯ No
If "Yes", please attach copy of declaration.

Do you know any reason why this claim should not be paid? ◯ Yes ◯ No
If "Yes", please give details.

For plan sponsor administered plans only

*Please submit a **COPY** of the enrolment form for this plan member.*

Plan member's insurance class (if applicable)	Most recent effective date of plan member's coverage (dd/mmm/yyyy)	Original effective date of dependant coverage (dd/mmm/yyyy)	Date to which premiums were paid (dd/mmm/yyyy)

2 Declaration

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

Plan sponsor signature	Date (dd/mmm/yyyy)	Plan sponsor phone number

Plan sponsor mailing address (number, street)	City	Province	Postal code

The information in this statement will become part of a group life and health benefits file which might be accessible by the plan member or third parties to whom access has been granted or those authorized by law.

3 Plan member statement

Plan member's mailing address (number, street)	City	Province	Postal code

Social Insurance Number	Date of birth (dd/mmm/yyyy)	Date of accident (dd/mmm/yyyy)	Time of accident ◯ A.M. ◯ P.M.

Please provide details of the occurrence, such as where, when and how it occurred.

Witness's name (last, first, middle initial)

Witness's mailing address (number, street)	City	Province	Postal code

Attending physician's name	Date of first visit to attending physician (dd/mmm/yyyy)

Attending physician's address (number, street)	City	Province	Postal code

Dependant information

(To be completed if a dependant claim is made.)

Dependant's mailing address (number, street)	City	Province	Postal code

Date of birth (dd/mmm/yyyy)	Marital status ◯ Married ◯ Single	Relationship to plan member

Date of accident (dd/mmm/yyyy)	Time of accident ◯ A.M. ◯ P.M.

Was the accident work-related? ◯ Yes ◯ No

Was the dependant confined to a hospital when coverage became effective? ◯ Yes ◯ No

If "Yes," indicate date discharged

(dd/mmm/yyyy)

If claiming for a dependant child who is attending school, name institution:

Institution

Was he/she dependent on you for financial support? ◯ Yes ◯ No

At the time of the accident, was the dependant employed? ◯ Yes ◯ No

If "Yes," indicate number of hours worked per week

No. of hours	Name of dependant's employer

Please provide details of the occurrence, such as where, when and how it occurred.

4 Certification, agreement and authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I also certify that any further verbal or written statement provided by me will be true and complete to the best of my ability.

I understand that Manulife Financial will investigate this claim and may require information regarding my employment, my activities and my health and health history, including clinical notes. I authorize any person or organization who has information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution 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 and exchange information requested by Manulife Financial and/or its claims service providers for the purpose of administering the group plan, assessing my claim and performing independent medical assessments.

I authorize Manulife Financial, its reinsurers and its claims service providers to collect, to use and to exchange with the persons or organizations listed above and/or each other any information needed for the purpose of plan administration, claim assessment, audit, investigation and management of my claim.

I authorize the use of my Social Insurance Number for the purpose of tax reporting and if my Social Insurance Number is used as my certificate number, I authorize its use for the identification and administration of my group benefits.

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 policies is available upon written request, on Manulife Financial's website, www.manulife.ca, or through my Plan Sponsor.

Plan member's signature	Date signed (dd/mmm/yyyy)

If claim for spouse, please have spouse sign and date.

Spouse's signature	Date signed (dd/mmm/yyyy)

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- Our employees and representatives in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.

Manulife Financial

Group Benefits
Initial Attending Physician's Statement
Group Accidental Dismemberment

Please print clearly.

1 Patient authorization

(To be completed by patient)

Patient's name (last, first, middle initial)	Plan number	Certificate number

"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 Patient information

Patient's name (last, first, middle initial)

Patient's mailing address (number, street)	City	Province	Postal code

Date of injury (dd/mmm/yyyy)	Date of first attendance for present injury (dd/mmm/yyyy)

Was injury caused while the patient was employed? ◯ Yes ◯ No

Please describe the injury.

If treated at hospital, please give name, address and details.

Hospital	Address of hospital

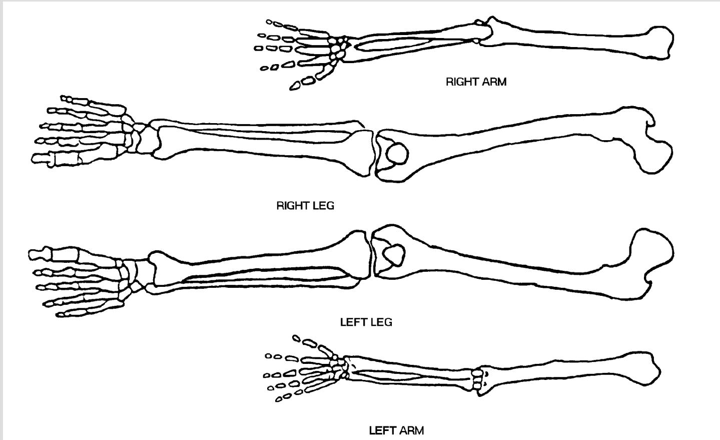
Details

Was the injury described **solely** responsible for the loss? ◯ Yes ◯ No

If "No", please give details of contributing causes and names and addresses of other physicians consulted.

3 Loss of limb

Please indicate where severance occurred.



Date (dd/mmm/yyyy)

Date (dd/mmm/yyyy)

Date (dd/mmm/yyyy)

Date (dd/mmm/yyyy)

Continued on back

4 Loss of sight

Did accident cause total loss of vision?

◯ Yes ◯ No If "Yes", indicate if: ◯ Both eyes ◯ Right eye only ◯ Left eye only

In your opinion, can vision be improved?

◯ Yes ◯ No If "Yes", indicate by: ◯ Treatment ◯ Operation ◯ Lenses

Please indicate vision in each eye prior to accident

Right eye (Snellen scale)	Left eye (Snellen scale)

Did accident require the removal of an eye?

◯ Yes ◯ No If "Yes", indicate if: ◯ Both eyes ◯ Right eye only ◯ Left eye only

Date of removal (dd/mmm/yyyy)

Please state your recommendations.

Please indicate present vision in each eye.

Right eye (Snellen scale)	Left eye (Snellen scale)

5 Physician's authorization

The information in this statement will become part of a GROUP, LIFE, HEALTH AND DISABILITY 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 (include area code) ( )
Address (number, street, city, province, postal code)	Fax (include area code) ( )
Physician's signature	Date signed (mmm/dd/yyyy)

Submitting form

You may give the completed form to your patient or send it directly to the appropriate address:

If you live outside Quebec:

Manulife Financial
Waterloo Group Life Claims Office
PO BOX 1629
WATERLOO ON N2J 4P6

If you live in Quebec:

Manulife Financial
Montreal Group Life Claims Office
PO BOX 395 STN PLACE D'ARMES
MONTREAL QC H2Y 3H1