Manulife Financial

Member Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of your disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your plan sponsor and your physician(s).

We ask you to provide information about what you are capable and incapable of doing, in relation to your job demands.

We ask your plan sponsor to tell us about your job demands.

We ask your physicians to provide us with information about your restrictions and limitations.

You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.

All of the above information will be reviewed to determine whether you meet the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Instructions for this form

Please complete all sections of this form, sign and date it, and return it to your plan administrator for submission to Manulife Financial (or; if you prefer, you can submit it directly to Manulife Financial, Group Disability Benefits, at the address below).

Authorization to attending physician

Please complete, sign and date the "Patient authorization" section at the top of page 3 of the Attending Physician's Statement form before you take it to your physician.

Our approach

Manulife Financial is committed to timely and effective return to work whenever possible. Should your claim for LTD benefits be accepted, we will review your situation and a representative of Manulife Financial will contact you to explore your current circumstances, and, if appropriate, develop a plan for your return to work.

Any questions?

Your plan administrator is the best person to answer any questions you may have about your LTD benefit plan or the application process.

Manulife Financial

Member Statement
Group Disability Claim

Additional information may be submitted on separate pages if there is insufficient space on this form.

1 Plan member information

You can obtain your plan number, account/division number, and your certificate number from your I.D. card.

Your plan number	Your Account/Division no.	Your certificate number	Your S.I.N.
Plan sponsor's name		Your job title	
Your full name (last, first, initial)	◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.	Your birthdate (dd/mmm/yyyy)	
Your street address (number, street and apartment)			
City	Province	Postal code	
Phone number ( )	Fax number ( )	Number of dependents and ages	
Mailing address (if different from above)			

2 Work information

a) Last day worked?

(dd/mmm/yyyy)

b) Prior to stopping work were you performing your usual job or had your job been modified?

◯ Yes ◯ No *If yes, how was it modified?*

c) If your work was modified, why were you unable to continue working?

d) How long were you performing modified work?

e) Since work absence commenced:

Have you attempted to work?	Dates (dd/mmm/yyyy) (from - to)	Describe
◯ Yes ◯ No		

3 Other activities information

a) Since work absence commenced:

Have you returned to school/retraining?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

Have you done volunteer activity?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

b) Have you received any money from these activities? ◯ Yes ◯ No

4 Injury information

a) Is work absence due to an injury? ◯ Yes ◯ No *If no, please go to section 6, Same illness information.*

b) What kind of injury? ◯ Motor vehicle accident ◯ Work related ◯ Other

c) Describe how and when injury occurred.

Date of injury (dd/mmm/yyyy)	Time of injury ◯ a.m. ◯ p.m.

d) Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide lawyer's name and address.*

(not required if claim is for waiver of premium benefit only)

Lawyer's name	Lawyer's address
Phone number	

e) Was the occurrence investigated by police? ◯ Yes ◯ No *If yes, please provide a copy of the police report.*

(not required if claim is for waiver of premium benefit only)

5 Motor vehicle accident information

(not required if claim is for waiver of premium benefit only)

a) If your work absence is related to a motor vehicle accident, please provide the following information:

Your insurer's name	Your insurance adjuster's name and phone number
Your insurance policy number or claim number	

6 Same illness information

a) Have you ever had the same or a similar illness? ◯ Yes ◯ No *If yes, state when and describe. If no, go to section 7, Medical information.*

b) Did the illness result in an absence from work? ◯ Yes ◯ No *If yes, state when.*

From (dd/mmm/yyyy)	To (dd/mmm/yyyy)

7 Medical information

a) Please provide the following information about the family doctor who has your MEDICAL RECORDS.

Last name of doctor	First name of doctor	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

b) Please provide the following information about ANY OTHER SPECIALIST OR HEALTH CARE PRACTITIONER you have seen or are scheduled to see for this condition. (e.g. chiropractor, physiotherapist, psychologist, etc.)

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

8 Income/Benefit information

a) Have you received 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.***

(not required if claim is for waiver of premium benefit only)

INCOME/BENEFIT	DATE OF APPLICATION (dd/mmm/yyyy)	REFERENCE OR CLAIM NUMBER	HAS THE INCOME/BENEFIT BEEN: *(Check all that apply)*			
			AWARDED?	DECLINED?	TERMINATED?	APPEALED?
QPP			◯	◯	◯	◯
CPP/S.S.B.			◯	◯	◯	◯
Workers' compensation*			◯	◯	◯	◯
Other group insurance			◯	◯	◯	◯
Association plan			◯	◯	◯	◯
Motor vehicle insurance			◯	◯	◯	◯
Salary continuation			◯	◯	◯	◯
Any short term plan			◯	◯	◯	◯
Employment insurance			◯	◯	◯	◯
Old age security			◯	◯	◯	◯
Retirement - government			◯	◯	◯	◯
Retirement - employer			◯	◯	◯	◯
Severance			◯	◯	◯	◯
Veteran's allowance			◯	◯	◯	◯
Social services			◯	◯	◯	◯
Creditor's disability insurance			◯	◯	◯	◯
Employment			◯	◯	◯	◯
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).*

9 Summary of education, training and experience

Please attach a copy of a current résumé, if available. Otherwise, please provide the following information.

a) **Education**

SCHOOL	LOCATION	LEVEL OBTAINED	YEAR	AREAS OF STUDY
Elementary school				
High school				
College or university				
Other (Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.)				

b) **Work experience**

Begin with most recent but include every job you have had in the last 15 years. If more space is required, please use additional sheets of paper.

DURATION OF EMPLOYMENT		EMPLOYER	JOB TITLE AND DUTIES
FROM	TO		

c) **Acquired skills**

If not already mentioned in the education section, these may include typing, operation of equipment, supervisory skills, special licenses or designations, etc. Where appropriate, give level, speed or proficiency.

10 Driver's license information

a) Does your job require you to have a professional license or designation? Please explain.

b) Do you have a valid driver's license?

◯ Yes ◯ No

Class	Indicate any restrictions

11 Other interests

Hobbies and interests, including any volunteer work.

12 Work capacity evaluation

In this section we are gathering information about your job duties and your ability or inability to do them. Please indicate the extent that you are now able to perform each activity that your job requires. If you have indicated "UNABLE TO DO", please provide primary reason.

PHYSICAL ACTIVITIES

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)	UNABLE TO DO (Please explain)
Sitting	◯	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯	◯	◯
Bending/Squatting	◯	◯	◯	◯	◯	◯	◯
Crouching	◯	◯	◯	◯	◯	◯	◯
Crawling	◯	◯	◯	◯	◯	◯	◯
Pushing	◯	◯	◯	◯	◯	◯	◯
Pulling	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; fingers	◯	◯	◯	◯	◯	◯	◯
Simple grasping	◯	◯	◯	◯	◯	◯	◯
Fine manipulation	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; hands	◯	◯	◯	◯	◯	◯	◯
Repetitive body motions	◯	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯	◯
Reaching - above shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - at shoulder level	◯	◯	◯	◯	◯	◯	◯
Reaching - below shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - side to side	◯	◯	◯	◯	◯	◯	◯
Reaching - up and down	◯	◯	◯	◯	◯	◯	◯

Lifting / Carrying	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY
Lifting - floor to waist	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - waist to shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - above shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Carrying	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant

PHYSICAL

Are you able to work in any of the following conditions?	Yes	No	If "No", please explain
Exposure to marked changes in temperatures and humidity	◯	◯	
Being around moving machinery	◯	◯	
Unprotected heights	◯	◯	
Exposure to dust, fumes and gases	◯	◯	
Driving automobile equipment	◯	◯	

In this section we are gathering information about your job duties and your ability or inability to do them. For each activity that your job requires of you, please indicate the extent to which you are able to do it. If you have indicated "UNABLE TO DO", please provide primary reason.

PSYCHOLOGICAL ACTIVITIES

A. Understanding and memory	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Remember locations and routine procedures	◯	◯	◯	◯	◯	◯	◯
Understand and remember short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Understand and remember detailed instructions	◯	◯	◯	◯	◯	◯	◯

B. Sustained concentration and persistence	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Carry out short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Carry out detailed instructions	◯	◯	◯	◯	◯	◯	◯
Maintain attention and concentration for extended periods	◯	◯	◯	◯	◯	◯	◯
Perform activities within a schedule	◯	◯	◯	◯	◯	◯	◯
Sustain an ordinary routine without supervision	◯	◯	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯	◯	◯
Solve simple straightforward problems	◯	◯	◯	◯	◯	◯	◯
Solve complex problems	◯	◯	◯	◯	◯	◯	◯

C. Social interaction	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Interact with the general public	◯	◯	◯	◯	◯	◯	◯
Ask questions or request assistance	◯	◯	◯	◯	◯	◯	◯
Accept instructions and feedback	◯	◯	◯	◯	◯	◯	◯
Get along well with others without distracting them	◯	◯	◯	◯	◯	◯	◯
Get along well with others without being distracted by them	◯	◯	◯	◯	◯	◯	◯

D. Adaptation	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Respond to frequent changes in the environment or tasks	◯	◯	◯	◯	◯	◯	◯
Aware of normal hazards and take appropriate precautions	◯	◯	◯	◯	◯	◯	◯
Travel in unfamiliar places or use public transportation	◯	◯	◯	◯	◯	◯	◯
Set realistic goals or make plans independently of others	◯	◯	◯	◯	◯	◯	◯
Juggle tasks and prioritize	◯	◯	◯	◯	◯	◯	◯

E. Responsibility and accountability	Yes	No
Is work pace without the pressure of deadlines?	◯	◯
Does the work involve occasional pressure to meet deadlines?	◯	◯
Does the work involve periodic pressure to meet deadlines?	◯	◯
Does the work involve significant pressures?	◯	◯

13 Other information

Please provide any additional information that you believe should be considered in assessing your claim.

14 When to contact Manulife Financial

NOTIFY MANULIFE FINANCIAL PROMPTLY IN THE FOLLOWING CASES.

I acknowledge I must notify Manulife Financial 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 discharged from hospital if I am now hospitalized,
g) I receive any other benefits/income related to my disability.
h) I am leaving the country.

Plan member's signature

15 Assignment, certification and authorization

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

I agree to refund any monies which may be due to Manulife Financial as a result of payment of disability benefits from any source listed above and/or in accordance with the provisions of the group benefit plan with Manulife Financial.

I understand Manulife Financial may investigate this claim. I authorize any employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, the Medical Information Bureau, any type of workers' compensation board or commission, group plan administrator, or any other corporation, organization, institution, association or person to release and exchange with Manulife Financial any medical or benefit payment information, or any other information or records that may be requested by Manulife Financial to process or manage 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 of this authorization shall be as valid as the original.

Plan member'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.

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