

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:

1 Plan sponsor	Plan contract number	Division number	Company name	
	Address (number, street)		City	Province
	Postal code		Telephone number ()	Fax number ()
	Contact name		Title	
Plan sponsor contribution to premiums STD _____ % <input type="radio"/> Non-taxable				
2 Plan member identification	Name (last, first, initial)			<input type="radio"/> Male
				<input type="radio"/> 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? <input type="radio"/> Full-time HRS/WK _____ <input type="radio"/> Part-time HRS/WK _____ <input type="radio"/> Shift work SHIFTS/WK _____ <input type="radio"/> 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 <input type="radio"/> Illness <input type="radio"/> Injury <input type="radio"/> On layoff <input type="radio"/> Leave of absence <input type="radio"/> Dismissed <input type="radio"/> Resigned <input type="radio"/> Strike <input type="radio"/> Other _____			
	Has the plan member returned to work? <input type="radio"/> Yes <input type="radio"/> No			
If yes, please provide (dd/mmm/yyyy) date returned to work.		If no, please provide (dd/mmm/yyyy) expected return date.		
Has coverage terminated? <input type="radio"/> Yes <input type="radio"/> 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				
<i>Please provide the following information, OR a copy of the current payslip.</i>				
Base salary/wage when member was last at work \$		Payment Schedule <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Bi-weekly <input type="radio"/> Semi-monthly <input type="radio"/> Monthly <input type="radio"/> Annual		
Commissions (if applicable) \$		(Please provide T4A documentation as per policy provisions)		Date of last salary change (dd/mmm/yyyy)
Other income (if applicable) \$		(Overtime, bonus, shift differential as per policy provisions)		

5 Tax information

Please provide the following information, **OR** a completed TD1 or TP1 form.

Please complete only if benefit is taxable.

TD1	TP1	Percentage to be deducted %	Member's province of residence for income tax purposes
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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Sick leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Vacation pay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Severance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$

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		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Carrying		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Sitting		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Standing		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> Constant
	Walking		<input type="radio"/> Infrequent	<input type="radio"/> Frequent	<input type="radio"/> 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.

Group Benefits Request for Direct Bank Deposit

Return completed form to:

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
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Address (number, street)	City	Province	Postal code
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Name of financial institution

Address (number, street)	City	Province	Postal code
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Type of account <input type="radio"/> Savings <input type="radio"/> Personal chequing <input type="radio"/> Current	Transit number	Bank account number
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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)
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Please attach your cheque sample marked "Void" here.

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.**

Return completed form to:

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)			<input type="radio"/> Mr. <input type="radio"/> Ms. Birthdate (dd/mmm/yyyy) <input type="radio"/> Miss <input type="radio"/> Mrs.
Social Insurance Number	Preferred language: <input type="radio"/> English <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No <i>If no, please go to item 3.</i>		
What kind of accident? <input type="radio"/> Motor vehicle accident <input type="radio"/> Work related <input type="radio"/> 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 <input type="radio"/> a.m. <input type="radio"/> p.m.
Is there any legal action involved? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please provide the following information:</i>		
Lawyer's name		Telephone number ()
Was the occurrence investigated by police? <input type="radio"/> Yes <input type="radio"/> No <i>If yes, please provide a copy of the police report.</i>		

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)		FREQUENCY				AMOUNT
		START	END	WEEKLY	BI-WEEKLY	MONTHLY	LUMP SUM	
		Any type of workers' compensation board*				<input type="radio"/>	<input type="radio"/>	
Motor Vehicle Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Employment Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Other				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$

* 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)
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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.**

Return completed form to:

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?	<input type="radio"/> Yes <input type="radio"/> No	
	If "Yes", state when and describe.		
	Is condition due to injury or sickness arising out of patient's employment?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
	Is a claim being submitted to any type of worker's compensation board?	<input type="radio"/> Yes <input type="radio"/> No	
	Has the patient been confined in a hospital?	<input type="radio"/> Yes <input type="radio"/> No	
	If available please include admission and discharge summaries.		
	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	Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)
	Monthly	Date of all visits between first and last visit (dd/mmm/yyyy)	
	Other (specify)		
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?			<input type="radio"/> Yes <input type="radio"/> No
Is there potential for future improvement?			<input type="radio"/> Yes <input type="radio"/> No
If no, please comment.			
Have you recommended that your patient's driver's licence be revoked?			<input type="radio"/> Yes <input type="radio"/> 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)
carrying	(max. weight/distance)	standing	(how long/frequency)
		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
<input type="radio"/> concentration				
<input type="radio"/> analytical reasoning				
<input type="radio"/> learning new material				
<input type="radio"/> comprehension				
<input type="radio"/> 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)	b) Blood pressure (last 3 visits)
<input type="radio"/> Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.	SYSTOLIC / DIASTOLIC
<input type="radio"/> Class 2 - Greater than ordinary physical activity results in symptoms.	SYSTOLIC / DIASTOLIC
<input type="radio"/> Class 3 - Ordinary physical activity results in symptoms.	SYSTOLIC / DIASTOLIC
<input type="radio"/> Class 4 - Symptoms at rest, and worse with any physical activity.	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.