Manulife

Standard Statement of Accident or Illness for Disability Insurance

Send this completed form to:

CC_987@manulife.com
Fax: 1-866-905-1112
Mail: Living Benefits Claims DMS
PO Box 1602 STN Waterloo
WATERLOO, ON N2J 4C6
Courier: Living Benefits Claims DMS
500 King St. N
Waterloo, ON N2J 4C6

Print clearly.

- *You* and *your* refer to the insured person.
- *We*, *us* and *our* refer to The Manufacturers Life Insurance Company.
- Use this form to provide details of your disability claim. Answer all questions fully. Incomplete forms may delay the claim.
- Return the completed Attending Physician's Statement section with pages 1-8 and any additional attached pages.
- If you have any questions call us at 1-866-575-0684 or visit manulife.ca.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

1 Personal information

Policy number	Name of insured person (first, middle initial, last)		Date of birth (dd/mmm/yyyy)
Residence address	City	Province	Postal code
Residence telephone number ( )	Social insurance number		

2 Disability information

Dates disabled:			
◯ Completely unable to work	From	To	
◯ Partially unable to work	From	To	

For disabilities involving the shoulder, arm or hand, are you ◯ Left handed **or** ◯ Right handed

Injury

Date of injury (dd/mmm/yyyy)	How and where did injury occur?	
When did injuries first cause lost time from work?	Date last worked (dd/mmm/yyyy) ◯ am ◯ pm	

Why did you stop working? ◯ Injury ◯ Other (Provide details below.)

Was the injury work-related? ◯ Yes ◯ No

What injuries did you receive?	Who witnessed the injury?

Have you ever had the same or a similar injury? ◯ Yes ◯ No

If *yes*, provide details (including when)

If injuries were the result of a motor vehicle accident, provide:

Name of vehicle owner

Insurance company through which the vehicle was insured	Policy number

If police were involved, provide officer's name, name of police force and badge number, if known

Illness

When did symptoms first:

a) appear	b) cause lost time from work	Date last worked (dd/mmm/yyyy) ◯ am ◯ pm

Why did you stop working? ◯ Illness ◯ Other (Provide details below.)

Nature and details of illness

Have you ever had the same or a similar illness? ◯ Yes ◯ No

If *yes*, provide details (including when)

3 Treatment information

Attending physicians' names and addresses (include postal code)	Date of first treatment (dd/mmm/yyyy)

If you did not consult a physician on the date the accident occurred or symptoms first appeared, explain why

Name and address of regular attending physician (if not already shown)

If you were hospitalized, provide hospital name and address (include postal code)	Date admitted (dd/mmm/yyyy)	Date discharged (dd/mmm/yyyy)

Are you still being treated for this condition? ◯ Yes ◯ No

Nature of treatment and frequency

Have you returned to work? ◯ Yes ◯ No

If *yes*, provide dates

◯ Full time ◯ Part time	Hours per week	◯ Regular occupation ◯ Another occupation

Provide details

If you have not returned to work, what date do you expect to return? (dd/mmm/yyyy)	◯ Full time ◯ Part time

Has your physician made you aware of what expectations are reasonable and what your responsibilities are in the recovery/rehabilitation and return to work process? ◯ Yes ◯ No

Provide details

4 Other benefits information

Indicate if you have any other benefits.

Benefit	Applied		Received		Company name	Policy number	Date applied for (dd/mmm/yyyy)	Amount received		Effective date (dd/mmm/yyyy)
	Yes	No	Yes	No				Weekly	Monthly	
Salary Continuation/ Sick Pay	◯	◯	◯	◯						
Auto Insurance Income Payments	◯	◯	◯	◯						
Workers' compensation	◯	◯	◯	◯						
Canada/Quebec Plan Disability	◯	◯	◯	◯						
Employment Insurance	◯	◯	◯	◯						
Retirement or Pension	◯	◯	◯	◯						

If you have other insurance policies providing a disability benefit including critical illness, creditor insurance, etc., provide the following information.

Applied		Received		Company name	Policy number	Issue date of policy (dd/mmm/yyyy)	Date payments started (dd/mmm/yyyy)	Benefit amount	Elimination period	Benefit period	Personal	Business overhead
Yes	No	Yes	No									
◯	◯	◯	◯								◯	◯
◯	◯	◯	◯								◯	◯
◯	◯	◯	◯								◯	◯

If there are no disability benefits payable at present, will you be eligible in the future? ◯ Yes ◯ No
If *yes*, provide details (eligibility date, amount elimination period, and benefit period) in the preceding table.

Remarks

Provide any other information which you feel may help us evaluate your claim properly.

5 Employment information

Immediately prior to becoming disabled were you employed? ◯ Yes ◯ No

Employer name	Telephone number ( )

Address	City	Province	Postal code

If you were not gainfully employed at the time you became disabled, indicate the last date you were employed prior to your disability

6 Occupational information

It is essential that you provide a complete and detailed description of your occupation at the time you became disabled in order that we may adjudicate your claim fairly and accurately. Note: this form is designed to encompass a wide variety of occupations. **If you were not gainfully employed, complete questions 6 through 10 based upon your usual daily activities.**

1. Job title _____
2. Are you self-employed? ◯ Yes ◯ No If *yes*, number of employees _____
3. Nature of business _____
4. Hours worked prior to disability _____
5. Length of time in position (in years) _____
6. Your monthly income prior to disability after the deduction of business expenses but before the deduction of income taxes _____

7 Licence status

1. Has your driver's licence or any professional licence or certification been suspended, restricted or revoked? ◯ Yes ◯ No

   If *yes*, specify the date (dd/mmm/yyyy) _____

   Type of licence _____ Class of licence _____

   If *no*, have there been any complaints, allegations or investigations undertaken? ◯ Yes ◯ No

   If *yes*, give details _____

2. Have you chosen not to renew any licence identified in question 1, above? ◯ Yes ◯ No

   If *yes*, give reasons _____

8 Business information

1. Are you a sole proprietor? ◯ Yes ◯ No

   If *yes*, name of the business _____

2. Are you in a partnership? ◯ Yes ◯ No

   % of ownership / # of partners _____

3. Are you an associate? ◯ Yes ◯ No

   Describe business relationship _____

4. Have you sold your business? ◯ Yes ◯ No

   Date of sale (dd/mmm/yyyy) _____

5. Is your business operating? ◯ Yes ◯ No

6. Have you hired someone to replace you? ◯ Yes ◯ No

   If *yes*, what is the individual's name? _____

9 Occupational duties

List all duties of your occupation. Do your best to describe all the important duties you performed in your occupation prior to disability.

Duty	Detailed description	Number of hours spent per week at each duty	Are you currently able to perform this activity?	
			Yes	No
			◯	◯
			◯	◯
			◯	◯
			◯	◯
			◯	◯
			◯	◯

Total hours worked per week

Have the duties listed above changed during the 24 months preceding the onset of disability? ◯ Yes ◯ No

If *yes*, describe the nature and reason for change _____

Other than those shown above, provide details on any other duties you are able to perform. For any duties you are currently able to perform, provide hours per week and days per week. Include any duties not shown above.

10 Work environment information

Does your occupation require work in any of the following conditions?	Yes	No	Times per day	Hours per day
Outside?	◯	◯		
In extremes of cold or heat?	◯	◯		
In a damp or humid environment?	◯	◯		
In an unventilated environment?	◯	◯		

Does your occupation involve handling: a) skin irritants (e.g. dust, fumes, gases, chemicals, etc.)? ◯ Yes ◯ No
b) respiratory irritants (e.g. dust, fumes, gases, chemicals, etc.)? ◯ Yes ◯ No

If *yes*, list the irritants

_____

11 Strength and mobility information

Does your occupation require	Yes	No	Times per day	Hours per day
lifting or carrying: from 5 - 25 pounds?	◯	◯		
more than 25 pounds?	◯	◯		
pushing or pulling: from 5 - 25 pounds?	◯	◯		
more than 25 pounds?	◯	◯		
sitting?	◯	◯		
standing?	◯	◯		
walking?	◯	◯		
climbing?	◯	◯		
driving?	◯	◯		
remaining in one position for more than 1 hour?	◯	◯		
Reaching: above shoulder height?	◯	◯		
at shoulder height?	◯	◯		
below shoulder height?	◯	◯		
twisting?	◯	◯		
bending or crouching?	◯	◯		
kneeling or crawling?	◯	◯		
balancing?	◯	◯		

Describe any factors that contribute to the amount of stress (physical or mental) associated with your occupation:

List any vehicles, office machines, tools or other equipment that you use in your occupation:

Type of equipment	Times per day	Hours per day

12 Authorization and consent

Read this section carefully. It explains how your personal information is used.

Your signature on page 8 means that you authorize and consent to the ways we collect, use, share and retain your personal information.

You may not alter any of the wording in Section 12. Any attempt to do so will be of no effect. For information on withdrawing your consent, consult the relevant sections on the next page.

In this statement, *you* and *your* refer to the policy owner or holder of rights under the policy, the life insured, and the parent or guardian (tutor, in Quebec) of any child named as life insured who is under the age of 16 (or under 18 in Quebec). *We*, *us*, *our*, and *the Company* refer to The Manufacturers Life Insurance Company, and our affiliated companies and subsidiaries.

Updates to this statement and further information about our privacy practices are posted to manulife.ca.

We collect, use, verify, and disclose your personal information for identified purposes, and only with your consent, or as permitted or required by law. By signing the application, you give your consent for us to collect, use, and disclose your personal information, as set out in this statement. Any alterations to the consent must be agreed to in writing by the Company.

What personal information do we collect?

Depending on the product you have applied for, we collect specific personal information about you, such as:

- identifying information, such as your name, address, telephone number(s), email address, your date of birth, driver's license, passport number, or Social Insurance Number (SIN)
- medical information that any organization or person has about you
- any test that may be necessary for us to decide if and on what terms to insure you, such as a medical exam or blood test
- your personal information from MIB, Inc., as explained in Information about MIB, Inc.
- a copy of all driving related information from provincial or territorial Motor Vehicle Divisions
- a personal investigation, financial information, credit bureau report, and/or a consumer report from other organizations, person, or source that has any information or records about you
- information about how you use our products and services, and information about your preferences, demographics, and interests
- other personal information we may require to administer our business relationship with you.

We use fair and lawful means to collect your personal information.

Where do we collect your personal information from?

We collect your personal information from:

- your completed applications, recorded teleinterviews, and forms
- other interactions between you and the Company
- other sources, such as:
  - your advisor or authorized representative(s)
  - third parties with whom we deal in issuing and administering your policy now and in the future
  - public sources, such as government agencies or internet sites.

What do we use your personal information for?

We will use your personal information to:

- help us properly administer the products and services that we provide, and to manage our relationship with you
- confirm your identity and the accuracy of the information you provide
- evaluate your application and issue and administer the rights under the policy
- comply with legal and regulatory requirements
- understand more about you and how you like to do business with us
- analyze data to help us understand our customers better, so we can improve the products and services we provide
- determine your eligibility for, and provide you with details of, other products or services that may be of interest to you.

continued...

12 Authorization and consent (continued)

Who do we disclose your information to?
We disclose your information to:
- persons, financial institutions, and other parties with whom we deal in issuing and administering your policy now and in the future
- authorized employees, agents, and representatives
- your advisor
- any agency that has entered into an agreement with us and has supervisory authority, directly or indirectly over your advisor, and their employees
- any person or organization to whom you gave consent
- people who are legally authorized to view your personal information
- service providers who require this information to perform their services for us (for example data processing, programming, data storage, market research, printing and distribution services, paramedical, and investigative agencies)
- your medical doctor
- public health authorities as required, if laboratory tests performed on our behalf show that you have tested positive for infectious disease.

The abovementioned people, organizations, and service providers are both within Canada and jurisdictions outside Canada, and would therefore be subject to the laws of those jurisdictions.

Where personal information is provided to our service providers, we require them to protect the information in a manner that is consistent with our privacy policies and practices.

The personal information you provided in this application:
- will become a part of all the contracts that result from this application, even if you are not the owner or one of the people to be insured for that printed contract
- will be shared with all the owners and any subsequent owners of those contracts and all people to be insured.

How long do we keep your information?
We keep your information the longer of:
- the time period required by law and by guidelines set for the financial services industry, or
- the time period required to administer the products and services we provide.

Withdrawing your consent
You may withdraw your consent for us to use your SIN or Business Number, if applicable, for non-tax administration purposes. You may also withdraw your consent for us to use your personal information to provide you with other service or product offerings, excluding those mailed with your statements.

You may not withdraw your consent for us to collect, use, retain, or disclose personal information we need to issue or administer the policy unless federal or provincial laws give you this right. If you do so, a policy may not be issued and benefits will not be payable under the policy, or we may treat your withdrawal of consent as a request to terminate the policy.

If you wish to withdraw your consent, phone our customer care centre at 1-888-MANULIFE (626-8543), or 1-888-MANUVIE (626-8843) in Quebec, or write to the Privacy Officer at the address below.

Accuracy and Access
You will notify us of any change to your contact information. You have the right to access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. If you have a question, a concern, or wish to receive more information about parties who have access to your information or about our privacy policies and procedures, and/or wish to review your personal information in our files or correct any inaccuracies, you may send a written request to:

Privacy Officer
Manulife
500 King Street N.
Waterloo, ON N2J 4C6
Privacy_office_canadian_division@manulife.ca

Please note the security of email communication cannot be guaranteed. Do not send us information of a private or confidential nature by email. By contacting us via email you are authorizing us to communicate with you by email.

continued...

12 Authorization and consent (continued)

Opting out of direct marketing

You have the right to opt out of additional product offerings. By withdrawing your consent for us to use your personal information for the purpose of marketing, you understand it will not affect our ability to continue to provide you with the products and services you have requested, but it will exclude you from receiving direct personalized marketing or special offers on other products and services.

How we resolve complaints

To discuss any questions or concerns you may have, please contact your advisor or our head office at:
1-888-626-8543 in all provinces except Quebec or
1-888-626-8843 in Quebec
More information about our complaint resolution process is available at manulife.ca under *Contact Us > Complaint resolution*.

13 Authorization to release information

This completed and signed section will be copied and provided to any hospitals or other organization as your authorization to release information to us for this claim.

In this section *we*, *us* and *our* refer to The Manufacturers Life Insurance Company; *you* and *your* refer to the insured person.

You authorize and direct any doctor, medical practitioner, health care professional, hospital, clinic and other medical or medically related facility, insurance company or their service providers, the Canada Revenue Agency, the Medical Information Bureau, other organization, institution, association or person that has any information, records or knowledge of you, to release to and exchange with us and applicable reinsurers any information about you that we require to administer this claim.

By signing below you are confirming that:
- to the best of your knowledge, all of the information in this claimant's statement is current, correct and complete
- you agree to the terms of this claimant's statement
- you make all authorizations and give your consent as described in this claimant's statement
- you agree that a copy of this authorization shall be as valid as the original.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Name of insured person (please print)	
Signature of insured person ✘	Date (dd/mmm/yyyy)
Signature of beneficiary (in applicable jurisdictions) or legal representative if insured person is a minor or is incompetent (attach applicable documents) ✘	Date (dd/mmm/yyyy)
Signature of witness ✘	Date (dd/mmm/yyyy)

Manulife

Attending Physician's Statement

Send this completed form to:

CC_987@manulife.com
Fax: 1-866-905-1112
Mail: Living Benefits Claims DMS
PO Box 1602 STN Waterloo
WATERLOO, ON N2J 4C6
Courier: Living Benefits Claims DMS
500 King St. N
Waterloo, ON N2J 4C6

- Use this form to provide medical information about the person identified in Section 1. To allow us to assess this claim, we need you to answer all of the questions in full. This information will be used to make decisions about any benefits payable. Regrettably, incomplete forms compromise our ability to reach a decision.
- If you have any questions, call us at 1-866-575-0684.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis, or prognosis.

Print clearly.

1 a) Personal information

All of Section 1 must be completed, signed and dated by the **insured person** before the physician completes sections 2 -13.

Policy number(s)	Name of insured person (first, middle initial, last)		Date of birth (dd/mmm/yyyy)
Address	**City**	**Province**	**Postal code**

1 b) Authorization by insured person to release personal information

By signing below:

- I authorize and direct the doctor preparing this Attending Physician's Statement to release information, records or knowledge of me and my health to The Manufacturers Life Insurance Company. The information will be used to administer a claim being made for the policy identified in Section 1 a).
- I agree that this authorization will be in effect for one year from the date I sign it.
- **I acknowledge that I am responsible for providing this form to my doctor to complete, and that I will have to pay any costs my doctor may charge for completing this form.**
- I understand that my personal information will be used and stored as described in Manulife's policy and procedures document.
  (This document is available from our Privacy Office, Individual Insurance, 25 Water St. S., PO BOX 800 STN C, KITCHENER ON N2G 4Y5 or on our website at manulife.ca>Privacy Policy.)

Signature of insured person or a representative if insured person is a minor or incompetent (attach applicable documents)	Date (dd/mmm/yyyy)
✘	

2 History

1. When did the symptoms first appear or accident happen? (dd/mmm/yyyy) _____
2. Date diagnosis of condition was first made (dd/mmm/yyyy) _____
3. Are you aware of the date your patient (specify):
   ◯ ceased work (dd/mmm/yyyy) _____ ◯ reduced work hours (dd/mmm/yyyy) _____
4. Is condition considered chronic? ◯ Yes ◯ No
   If *yes*, what precipitated absence from work? _____
5. Has patient ever had same or similar condition? ◯ Yes ◯ No ◯ Unknown
   If *yes*, state when and describe _____
6. Is condition due to injury or sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown
7. Current height _____ Current weight _____

3 Diagnosis

▶▶ If this is a psychiatric condition, complete section 6. Skip sections 3–5.

1. Primary diagnosis (including any complications) _____
2. Secondary diagnosis (if applicable) _____
3. Were there any precipitating factors? (specify) _____
4. Additional conditions/complications which may prolong recovery _____
5. If condition is due to pregnancy what is/was the expected date of confinement? (dd/mmm/yyyy) _____
6. Provide copies of your consultation notes in support of the stated diagnosis from the onset to the current date.

4 Symptoms

1. Objective findings (attach copies of any x-ray reports, diagnostic tests/investigations, laboratory data or hospital admission/discharge/operative reports)

2. Symptoms (list all)

4 Symptoms *(continued)*

3.

Diagnostic tests	Date (dd/mmm/yyyy)	Results

4. Are you planning any future diagnostic tests? ◯ Yes ◯ No If *yes*, provide details.

5 Restrictions and limitations

Can your patient: (If *yes*, provide times/day **and** hours/day)

	Yes	No	Times/day	Hours/day		Yes	No	Times/day	Hours/day
Lift or carry up to 25 lbs	◯	◯			Remain standing for 1 hour	◯	◯		
more than 25 lbs	◯	◯			Reach: above shoulder	◯	◯		
Push or pull up to 25 lbs	◯	◯			at shoulder height	◯	◯		
more than 25 lbs	◯	◯			below shoulder	◯	◯		
Sit	◯	◯			Twist	◯	◯		
Stand	◯	◯			Bend or crouch	◯	◯		
Walk	◯	◯			Kneel or crawl	◯	◯		
Climb	◯	◯			Other: _____	◯	◯		

6 Psychiatric disorders

Complete this section *only* if this is a psychiatric condition.

1. Diagnosis – (use DSM IV terminology and codes)

   Axis I _____

   Axis II _____

   Axis III _____

   (If Axis III diagnosis given, complete sections 3, 4 and 5)

   Axis IV _____

   Axis V _____

2. Provide copies of your consultation notes in support of the stated diagnosis from the onset to the current date.
3. History: Positive family history ◯ Yes ◯ No

   If *yes*, explain _____

   Past psychiatric history (diagnosis, year, duration, etc.) _____

4. Current illness (list all symptoms)

Symptom	Frequency	Duration

6 Psychiatric disorders *(continued)*

5. Other factors influencing illness (job, home, relationships, status of professional licence, bankruptcy, etc.)

6. Is there now or has there ever been an alcohol or substance abuse problem? ◯ Yes ◯ No
   Provide details regarding dates and treatments

Date from (dd/mmm/yyyy)	Date to (dd/mmm/yyyy)	Treatment

7 Treatment

1. Date of first visit (dd/mmm/yyyy) _____
2. All dates of office visits in the last 6 months (dd/mmm/yyyy) _____
   If no visits during the last 6 months, indicate date of last visit (dd/mmm/yyyy) _____
3. If medication is being administered, describe below:

Medication	Dosage	Date started (dd/mmm/yyyy)	Date stopped (dd/mmm/yyyy)

4. Was patient admitted to a treatment facility or hospital? ◯ Yes ◯ No If *yes*, give details.

   _____

   Name of facility or hospital _____

   Date of admission (dd/mmm/yyyy) _____ Date of discharge (dd/mmm/yyyy) _____

   Date and description of surgery (dd/mmm/yyyy) _____
5. Other treatment (e.g. therapy), describe _____
6. Projected duration of treatment plan _____
7. Has your patient been made aware of what expectations are reasonable and of their responsibilities in the recovery/rehabilitation and return to work process?
   ◯ Yes ◯ No If *yes*, elaborate _____
8. Details of any proposed/future treatment plan _____
9. Specify the response to treatment:
   ◯ Recovered ◯ Improved ◯ Remains unchanged ◯ Retrogressed
10. Is patient following treatment plan? ◯ Yes ◯ No If *no*, explain.

8 Treating physicians

List all treating physicians.

Name	Speciality	Address

If there has not been a specialist referral, provide details

9 Licence status

Has your patient's driver's licence or any professional licence or certification been restricted or revoked as the result of their condition? ◯ Yes ◯ No

If *yes*, specify the type of licence _____

Class of licence _____ Date restricted/revoked (dd/mmm/yyyy) _____

Have you been asked to provide any information (oral or written) to any government agency, professional association or licensing bureau on behalf of your patient? ◯ Yes ◯ No

10 Other insurance

Are you providing information regarding your patient's condition to any other insurers? (e.g. CPP, any type of workers' compensation plan, other insurance companies) ◯ Yes ◯ No

Company names	Policy numbers

11 Competency

Do you believe the patient is mentally competent, including the ability to endorse cheques and direct the use of the proceeds? ◯ Yes ◯ No

If *no*, from what date? (dd/mmm/yyyy)	Who has been appointed Power of Attorney/Committee of Estate?

12 Smoking history

Does your patient currently use any form of tobacco? ◯ Yes ◯ No

If *yes*, from what date? (dd/mmm/yyyy) _____

Is there a previous history of tobacco use? ◯ Yes ◯ No

If *yes*, provide dates:

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

Remarks

Provide any further comments and details you feel would be helpful.

13 Physician's signature

Note: The patient is responsible for paying any fee charged for completion of this Attending Physician's Statement.

Provide copies of your consultation notes, specialist or hospital reports, current x-rays, tests/investigations, laboratory data and any clinical findings.

By signing below you confirm that to the best of your knowledge, the information on this statement about the patient is current, correct and complete.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis, or prognosis.

Name of physician (first, middle initial, last) **Print clearly.**			Telephone number ( )
Address	City	Province	Postal code
Certified specialist ◯ No ◯ Yes, please specify			
Signature of physician ✘			Date (dd/mmm/yyyy)