Manulife

Please send completed form to:
Manulife Group Benefits
Attention: Disability Claims
P.O. Box 800 Station Waterloo, Waterloo, Ontario N2J 4C2
Tel.: 1-877-481-9169 Fax.: 1-866-677-4215
Email: **group_disability_claims@manulife.ca**

Group Benefits Plan Member Statement
Group Disability Claim Form

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form.
Refer to your booklet for information about your plan.

1. Benefit application

Please select the benefit type for which the plan member is applying.

◯ Short-term disability ◯ Long-term disability ◯ Waiver of premiums ◯ Critical illness ◯ Dismemberment

2. Plan member information

You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.

Plan sponsor name: _____

Plan contract number: _____ Division: _____ Certificate number: _____

Full name (first, middle initial, last): _____

SIN (if benefit is taxable): _____ Date of birth (dd/mmm/yyyy): _____

Sex*: ◯ Male ◯ Female ◯ Non-binary

* Select male, female or non-binary consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Height: _____ Weight: _____ Number of dependants and ages: _____ Language preference: ◯ English ◯ French

Street address (number, street, apt): _____

City: _____ Province: _____ Postal code: _____

Primary phone number: ( ) _____ Alternate phone number: ( ) _____ Work phone number: ( ) _____ Ext. _____

By providing my personal email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

Email Address: _____

3. Direct deposit authorization

If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.

◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement**

◯ **If depositing into a chequing account, please sign the authorization, and attach a copy of a void cheque**

Name of financial institution: _____

Address of financial institution (number, street, suite): _____

City: _____ Province: _____ Postal code: _____

Type of account: ◯ Chequing ◯ Savings

Branch or transit number (5 digits): _____ Institution number (3 digits): _____

Bank account number (maximum 12 digits): _____

Continued on the next page.

3. Direct deposit authorization (continued)

I hereby authorize Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. **I agree** that Manulife 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 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. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan member signature: _____ Date (dd/mmm/yyyy): _____

Plan member name (please print): _____

If providing a copy of a void cheque, please place it here.

4. Injury information

Occupation: _____ Original date of hire (dd/mmm/yyyy): _____

Is your injury/illness work related? ◯ Yes ◯ No

If **no**, was the reason you stopped working due to: ◯ Illness ◯ Injury away from work ◯ Motor vehicle accident (Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

Is there any legal action? ◯ Yes ◯ No If **yes**, please provide the lawyer's contact information.

Lawyer's name: _____ Phone number: ( ) _____ Ext. _____

Lawyer's address (number, street, suite): _____

City: _____ Province: _____ Postal code: _____

5. Work information

What was the last date at work? (dd/mmm/yyyy): _____

Was this a full day/shift? ◯ Yes ◯ No If **no**, how many hours were worked on your last day? _____

Have you performed any other paid or volunteer work since that date? ◯ Yes ◯ No

If **yes**, please describe. Dates (dd/mmm/yyyy):

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

6. Illness information

When were you first treated by a physician for the current absence? (dd/mmm/yyyy): ______________

Please describe your symptoms and their frequency.

What work duties do your symptoms prevent you from performing?

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

Did it result in an absence from work? ◯ Yes ◯ No If **yes**, please describe, include dates and treatment provided.

Do you have an expected return to work date? ◯ Yes ◯ No If **yes**, please provide the date (dd/mmm/yyyy): ______________

7. Health care professional information

Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name: ______________ Specialty: ______________

Address of health care professional (number, street, suite): ______________

City: ______________ Province: ______________ Postal Code: ______________

Phone number: ( ) ______________ Fax number: ( ) ______________

Consulted:

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

Date of next visit (dd/mmm/yyyy): ______________ Frequency of visits: ______________

Name: ______________ Specialty: ______________

Address of health care professional (number, street, suite): ______________

City: ______________ Province: ______________ Postal Code: ______________

Phone number: ( ) ______________ Fax number: ( ) ______________

Consulted:

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

Date of next visit (dd/mmm/yyyy): ______________ Frequency of visits: ______________

Name: ______________ Specialty: ______________

Address of health care professional (number, street, suite): ______________

City: ______________ Province: ______________ Postal Code: ______________

Phone number: ( ) ______________ Fax number: ( ) ______________

Consulted:

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

Date of next visit (dd/mmm/yyyy): ______________ Frequency of visits: ______________

8. Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and **submit a copy of your notice of acceptance**, if applicable.

Source	Have you applied?		Are you receiving payment?		Date benefit commenced? (dd/mmm/yyyy)	Amount ($)	Please describe or provide claim number, contact name and telephone number
	Yes	No	Yes	No			
Canada/Quebec Pension Plan ◯ Disability ◯ Retirement	◯	◯	◯	◯			
Worker's compensation*	◯	◯	◯	◯			
Employment insurance	◯	◯	◯	◯			
Auto insurance	◯	◯	◯	◯			
Other insurance	◯	◯	◯	◯			
Income from any other source	◯	◯	◯	◯			

* Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

9. Authorization and consent

Please sign this authorization and send to Manulife using one of the following methods.

Via fax: 1-866-677-4215

Via email: **group_disability_claims@manulife.ca**

Via regular mail to: **Manulife Group Benefits**
Attention: Disability Claims, P.O. Box 800 Station Waterloo, Waterloo, Ontario N2J 4C2

The words 'we,' 'us,' 'our,' and 'we've' mean The Manufacturers Life Insurance Company (Manulife) and their affiliated companies and subsidiaries. The words 'you', 'you're,' and 'your' mean the person submitting this claim.

Your information
All information given, as well as any future verbal or written information relating to this claim, is true and complete to the best of your knowledge.

If you give false, incomplete, or misleading information as part of this claim, or in the future in connection with this claim, you understand that according to the terms of your group plan and/or the contract your employer has with Manulife:
- coverage for you and your family members may be void;
- claims under this coverage may be denied and not paid; and/or
- if claims were paid by Manulife in error, or if you need to refund any money owed to Manulife in accordance with the provisions of the group benefits plan, we may recover those funds from you.

You will tell us right away if:
- your medical condition improves, even if you haven't returned to work
- you receive any benefits or income from any other source
- you start work as an employee or as a self-employed person
- you apply for any workers' compensation benefits
- you apply for benefits under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)
- you leave the country or travel within the country
- you're returning to school, or will be returning to school
- you are admitted to or discharged from a hospital

Your privacy
You've read and understand our **privacy policy** and you agree to the **Personal Information Statement** found at **manulife.ca** and authorize us and our affiliates to collect, use, maintain, store, and share your information as explained in that statement.

You also agree that the information that you have authorized us to collect may be:
- **Collected and used** to evaluate, issue, administer, and/or manage the products and services that we provide to you, to manage your relationship with us, confirm your identity and the accuracy of information you provide, comply with legal and regulatory requirements, understand more about you and how you like to do business; analyzed to help us understand our customers better so you can be given information about other products or services; and perform audits and investigations.
- **Shared with, accessed by, and maintained** by us or third parties that we work with to administer products and services that we provide to you; authorized employees, agents, and representatives; service providers who require information to perform their services for us; your plan administrator; reinsurers and their service providers; administrators of government benefits or other benefits programs; people who are legally authorized to view your information and any person or organization you give consent to. Except where there are contractual or legislative restrictions, these parties may be within and outside of Canada. Therefore, your personal information pertaining to this claim may be subject to interprovincial or cross-border transfers and be governed by the laws of those jurisdictions in order to provide services to you.

Automated processing of your personal information may help us to make disability claim decisions. For more information on decisions based exclusively on automated processing of personal information you can review our **privacy policy** here.

Your medical information
You authorize the release of your medical and health information in your file to us and our authorized agents for the purposes of assessing your disability claim and administering the benefits plan.

Continued on the next page.

9. Authorization and consent (continued)

Examples of medical and health information include consultation reports, clinical notes, test results, and hospital records. Medical and health information doesn't include genetic test results.

You understand that your medical and health information will not be given to your employer or plan sponsor unless your consent is explicitly obtained.

Manulife can share and discuss with your Employer information regarding your functional limitations, restrictions and obstacles to return to work for the purpose of confirming the anticipated duration of your functional limitations and/or your workplace absence and assisting in your return to work.

Information you give that is related to this claim will be kept in a group benefits disability file.

Your social insurance number (SIN)
Where Manulife is responsible for payment of benefits, you authorize the use of your SIN:
- to facilitate your request for payments by direct deposit
- for tax reporting
- for identification and administration, if your SIN is used as your plan member certificate number

Consent
You understand and agree that for your disability claim, we may:
- communicate with you and provide you with required disclosures electronically
- use electronic records

You agree that a photocopy or electronic version of this consent shall be as valid as the original.
You may revoke your consent in writing at any time.

Access, Accuracy and Withdrawals
You have the right to request access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. You also have the right to withdraw consent to the use and disclosure of your personal information where it will not impact the provision of services or is not required at law.

To access or rectify your personal information files or withdraw consent contact (Manulife at 1-877-481-9169 or **group_disability_claims@manulife.ca**) or write to the Privacy Officer at the address below.

Chief Privacy Officer
Manulife
P.O. Box 1602
Del Station 500-4-A
Waterloo, Ontario N2J 4C6
Canada_Privacy@manulife.ca

By signing this form, you acknowledge that you have read, understood and agree to the content of this authorization, as well as the **Personal Information Statement** available at **manulife.ca**.

Plan member signature: _____ Date (dd/mmm/yyyy): _____

Plan member name (please print): _____

Print

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.