Manulife Financial

Group Benefits
Plan Member/Dependant Statement
Accidental Dismemberment Claim

INSTRUCTIONS
If a claim is made for a dependant, 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 any fees related to the completion of this form.***

1 Plan sponsor statement for plan member accidental dismemberment

Plan contract number(s)	Class	Division number	Plan member 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 claim is made for a dependant.)

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 Plan sponsor declaration

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. 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.

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

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

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 claim is made for a dependant.)

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

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

Details of accident

Date of accident (dd/mmm/yyyy) | Time of accident ☐ A.M. ☐ P.M. | Was the accident work-related? ☐ Yes ☐ No

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

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

If attending school, name institution: Institution

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

Was the dependant confined to a hospital when coverage became effective? ☐ Yes ☐ No | If "Yes," indicate date discharged (dd/mmm/yyyy)

4 Certification, agreement and authorization

I certify that the information in this form, and any further verbal or written statement provided by me/my spouse and/or dependants of minor or major age; 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.

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.

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 plan member certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

I understand that Manulife Financial's Privacy Policy and related materials 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)

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

Signature: Spouse/dependant (of major age) | Date signed (dd/mmm/yyyy)

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 contract number	Plan member certificate number

I hereby authorize the release to Manulife Financial any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments. **I understand that I am responsible for any fees related to the completion of this form.**
I understand that Manulife Financial's Privacy Policy and related materials 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.

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**

Did the injury occur at work?
☐ Yes ☐ No

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

Please describe the injury.

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

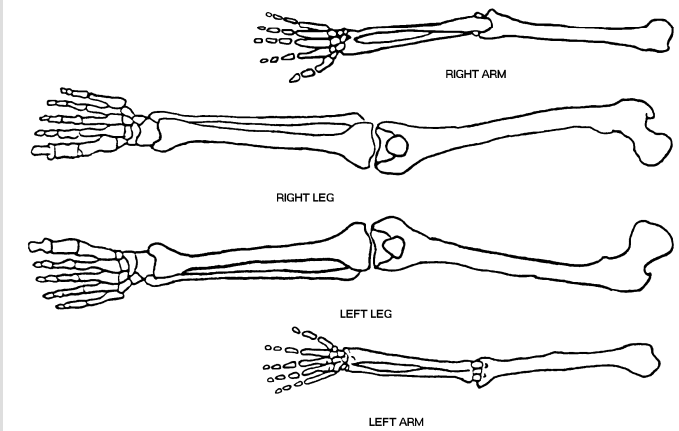
Hospital	Address of hospital

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 page 4

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 Other losses

Describe the nature and extent of the impairment resulting from the injury.

Is the loss sustained permanent and irrecoverable?

Comments

6 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 (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:

Manulife Financial
Halifax Group Life Claims Office
PO BOX 1030 STN CENTRAL
HALIFAX NS B3J 2X5

If you live in Quebec:
Manulife Financial
Montreal Group Life Claims Office
PO BOX 395 STN PLACE D'ARMES
MONTREAL QC H2Y 3H1