Manulife

Group Benefits
Plan Employer 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, GL4590E(31800)(82600), and an Attending Physician's Statement, GL4587E(31800)(82600), 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, GL4587E(31800)(82600), on page 1 before they take it to their physician.

Return completed form to: **Prairie Teamsters Administration Services**
155 - 7260 12 ST SE
CALGARY AB T2H 2S5
Tel: (403) 252-6924 Fax: (403) 253-3231

OR Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 4217 STN C, CALGARY AB T2T 5N1
Telephone: 1-877-481-9169 Fax: 1-866-635-3050

1 Plan employer

Plan contract number | Division number | Company name

2 Plan member identification

Name (last, first, initial) | ◯ Male ◯ Female

Social Insurance 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?
◯ Full-time HRS/WK _____ ◯ Part-time HRS/WK _____ ◯ Shift work SHIFTS/WK _____ ◯ Other HRS/WK _____

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
◯ Illness ◯ Injury ◯ On layoff ◯ Leave of absence
◯ Dismissed ◯ Resigned ◯ Strike ◯ Other _____

Has the plan member returned to work? ◯ Yes ◯ No

If yes, please provide date returned to work. (dd/mmm/yyyy) *If no, please provide expected return date.* (dd/mmm/yyyy)

Has coverage terminated? ◯ Yes ◯ No *If yes, please state when and reason why.*

Date coverage terminated (dd/mmm/yyyy) | Reason for termination of coverage

4 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).

5 Job description

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.)

6 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		◯ Infrequent ◯ Frequent ◯ Constant
Carrying		◯ Infrequent ◯ Frequent ◯ Constant
Sitting		◯ Infrequent ◯ Frequent ◯ Constant
Standing		◯ Infrequent ◯ Frequent ◯ Constant
Walking		◯ Infrequent ◯ Frequent ◯ Constant

7 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.

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