Manulife

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, GL4587E(31800)(82600), and photocopies of file documentation.**

Return completed form to: **Prairie Teamsters Administration Services**
155 - 7260 12 ST SE
CALGARY AB T2H 2S5
Telephone: (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 member information

Plan contract number | Division number | Social Insurance Number

Plan employer's name | Job title

Plan member's full name (last, first, initial) | ◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.

Date of birth (dd/mmm/yyyy) | Preferred language: ◯ English ◯ French | Height | Weight

Full address (number, street and apartment)

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? ◯ Yes ◯ No *If no, please go to section 3.*

What kind of accident?

◯ Motor vehicle accident ◯ Work related ◯ 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 ◯ a.m. ◯ p.m.

Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide the following information:*

Lawyer's name | Telephone number

Was the occurrence investigated by police? ◯ Yes ◯ No
If yes, please provide a copy of the police report.

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, street and 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, street and 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) START / END	FREQUENCY: WEEKLY	BI-WEEKLY	MONTHLY	LUMP SUM	AMOUNT
Any type of workers' compensation board*			◯	◯	◯	◯	$
Motor Vehicle Insurance			◯	◯	◯	◯	$
Employment Insurance			◯	◯	◯	◯	$
Other			◯	◯	◯	◯	$

* 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 website: 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 signature / Date signed (dd/mmm/yyyy)

6 Certification, agreement and authorization *(continued)*

PRINT

I authorize Manulife Financial and Prairie Teamsters Administration Services Ltd. to release to and/or exchange with each other, any personal information gathered through the claim adjudication and rehabilitation process including, but not limited to, my diagnosis, all medical information, consultation reports, independent medical reports, and hospital records and medically specific declination or termination letters, for the purposes of facilitating my return to work, and facilitating my understanding of Manulife Financial's claim decisions. **I understand** no information unrelated to my work restrictions will be transmitted to my employer.

Plan member signature	Date signed (dd/mmm/yyyy)