[redacted]

Manulife Financial

Member Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of your disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your plan sponsor and your physician(s).

We ask you to provide information about what you are capable and incapable of doing, in relation to your job demands.

We ask your plan sponsor to tell us about your job demands.

We ask your physicians to provide us with information about your restrictions and limitations.

You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.

All of the above information will be reviewed to determine whether you meet the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Instructions for this form

Please complete all sections of this form, sign and date it, and return it to your plan administrator for submission to Manulife Financial (or; if you prefer, you can submit it directly to Manulife Financial, Group Disability Benefits, at the address below).

This form must be fully completed by the plan member and submitted no later than 6 weeks prior to the expiration of the Long Term Disability Qualifying period.

Authorization to attending physician

Please complete, sign and date the "Patient authorization" section at the top of page 3 of the Attending Physician's Statement form before you take it to your physician.

Our approach

Manulife Financial is committed to timely and effective return to work whenever possible. Should your claim for LTD benefits be accepted, we will review your situation and a representative of Manulife Financial will contact you to explore your current circumstances, and, if appropriate, develop a plan for your return to work.

Any questions?

Your plan administrator is the best person to answer any questions you may have about your LTD benefit plan or the application process.

Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Tel: 1-800-465-2076
(416) 687-5049
Fax: (416) 687-5132
(416) 687-5211

Manulife Financial

Group Benefits Member Statement

Group Disability Claim

Additional information may be submitted on separate pages if there is insufficient space on this form.

1 Plan member information

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

Plan sponsor's name	Plan contract number	Division no.	Plan member certificate number

S.I.N.	Job title

Full name (last, first, initial)	◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.	Birthdate (dd/mmm/yyyy)

Street address (number, street and apartment)

City	Province	Postal code

Phone number ( )	Fax number ( )	Height	Weight

Number of dependants and ages	Mailing address (if different from above)

2 Work information

a) Last day worked? (dd/mmm/yyyy)

b) Prior to stopping work had your job been modified? ◯ Yes ◯ No *If yes, how was it modified?*

c) If your work was modified, why were you unable to continue working?

d) How long were you performing modified work?

e) Since work absence commenced:

Have you done any work for pay? ◯ Yes ◯ No	Dates (dd/mmm/yyyy) (from - to)	Describe

3 Other activities information

Since work absence commenced:

Have you returned to school/retraining?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

Have you done volunteer activity?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

4 Injury information

a) Is work absence due to an injury? ◯ Yes ◯ No *If no, please go to section 6, Illness information.*

b) What kind of injury? ◯ Motor vehicle accident ◯ Work related ◯ Other

c) Describe how and when injury occurred.

Date of injury (dd/mmm/yyyy)	Time of injury ◯ a.m. ◯ p.m.

d) Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide lawyer's name and address.*
(not required if claim is for waiver of premium benefit only)

Lawyer's name	Lawyer's address
Phone number	

e) Was the occurrence investigated by police? ◯ Yes ◯ No *If yes, please provide a copy of the police report.*
(not required if claim is for waiver of premium benefit only)

5 Motor vehicle accident information

(not required if claim is for waiver of premium benefit only)

a) If your work absence is related to a motor vehicle accident, please provide the following information:

Your insurer's name	Your insurance adjuster's name and phone number
Your insurance policy number or claim number	

6 Illness information

a) Have you ever had the same or a similar illness? ◯ Yes ◯ No *If yes, state when and describe. If no, go to section 7, Medical information.*

b) Did the illness result in an absence from work? ◯ Yes ◯ No *If yes, state when.*

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

c) Describe your current condition, including how it prevents you from working.

7 Medical information

a) Please provide the following information about the family doctor who has your MEDICAL RECORDS.

Last name of doctor	First name of doctor	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

b) Please provide the following information about ANY OTHER SPECIALIST OR HEALTH CARE PRACTITIONER you have seen or are scheduled to see for this condition. (e.g. chiropractor, physiotherapist, psychologist, etc.)

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

8 Income/Benefit information

Have you received 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.

(not required if claim is for waiver of premium benefit only)

Receipt of any benefits, including the following may result in a reduction to the benefit you receive from Manulife Financial and may require reimbursement to Manulife Financial of any benefit paid under this claim. It is imperative that you notify us of any change in the status of these benefits.

INCOME/ BENEFIT	DATE OF APPLICATION (dd/mmm/yyyy)	REFERENCE OR CLAIM NUMBER	CURRENT STATUS: *(Check all that apply)*				
			PENDING?	AWARDED?	DECLINED?	TERMINATED?	APPEALED?
QPP			○	○	○	○	○
CPP/S.S.B.			○	○	○	○	○
Workers' compensation*			○	○	○	○	○
Other group insurance			○	○	○	○	○
Association plan			○	○	○	○	○
Motor vehicle insurance			○	○	○	○	○
Salary continuation			○	○	○	○	○
Any short term plan			○	○	○	○	○
Employment insurance			○	○	○	○	○
Old age security			○	○	○	○	○
Retirement - government			○	○	○	○	○
Retirement - employer			○	○	○	○	○
Severance			○	○	○	○	○
Veteran's allowance			○	○	○	○	○
Social services			○	○	○	○	○
Creditor's disability insurance			○	○	○	○	○
Employment			○	○	○	○	○
Any other Manulife plan			○	○	○	○	○

**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).*

9 Summary of education, training and experience

Please attach a copy of a current résumé, if available. Otherwise, please provide the following information.

a) Education

SCHOOL	LOCATION	LEVEL OBTAINED	YEAR	AREAS OF STUDY
Elementary school/ High school				
College or university				
Other (Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.)				

b) Work experience

Begin with most recent but include every job you have had in the last 15 years. If more space is required, please use additional sheets of paper.

DURATION OF EMPLOYMENT		EMPLOYER	JOB TITLE AND DUTIES
FROM	TO		

c) **Acquired skills**

If not already mentioned in the education section, these may include typing, operation of equipment, supervisory skills, special licenses or designations, etc. Where appropriate, give level, speed or proficiency.

10 Driver's license information

a) Does your job require you to have a professional license or designation? Please explain.

b) Do you have a valid driver's license?

◯ Yes ◯ No

Class	Indicate any restrictions

11 Other interests

Hobbies and interests, including any volunteer work.

12 Work capacity evaluation

In this section we are gathering information about your job duties and your ability or inability to do them. Please indicate the extent that you are now able to perform each activity that your job requires. If you have indicated "UNABLE TO DO", please provide primary reason.

PHYSICAL ACTIVITIES

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)	UNABLE TO DO (Please explain)
Sitting	◯	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯	◯	◯
Bending/Squatting	◯	◯	◯	◯	◯	◯	◯
Crouching	◯	◯	◯	◯	◯	◯	◯
Crawling	◯	◯	◯	◯	◯	◯	◯
Pushing	◯	◯	◯	◯	◯	◯	◯
Pulling	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; fingers	◯	◯	◯	◯	◯	◯	◯
Simple grasping	◯	◯	◯	◯	◯	◯	◯
Fine manipulation	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; hands	◯	◯	◯	◯	◯	◯	◯
Repetitive body motions	◯	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯	◯
Reaching - above shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - at shoulder level	◯	◯	◯	◯	◯	◯	◯
Reaching - below shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - side to side	◯	◯	◯	◯	◯	◯	◯
Reaching - up and down	◯	◯	◯	◯	◯	◯	◯

Lifting / Carrying	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY		
Lifting - floor to waist	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Lifting - waist to shoulder	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Lifting - above shoulder	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Carrying	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant

PHYSICAL

Are you able to work in any of the following conditions?	Yes	No	If "No", please explain
Exposure to marked changes in temperatures and humidity	◯	◯	
Being around moving machinery	◯	◯	
Unprotected heights	◯	◯	
Exposure to dust, fumes and gases	◯	◯	
Driving automobile equipment	◯	◯	

PSYCHOLOGICAL ACTIVITIES

In this section we are gathering information about your job duties and your ability or inability to do them. For each activity that your job requires of you, please indicate the extent to which you are able to do it. If you have indicated "UNABLE TO DO", please provide primary reason.

A. Understanding and memory	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Remember locations and routine procedures	◯	◯	◯	◯	◯	◯	◯
Understand and remember short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Understand and remember detailed instructions	◯	◯	◯	◯	◯	◯	◯

B. Sustained concentration and persistence	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Carry out short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Carry out detailed instructions	◯	◯	◯	◯	◯	◯	◯
Maintain attention and concentration for extended periods	◯	◯	◯	◯	◯	◯	◯
Perform activities within a schedule	◯	◯	◯	◯	◯	◯	◯
Sustain an ordinary routine without supervision	◯	◯	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯	◯	◯
Solve simple straightforward problems	◯	◯	◯	◯	◯	◯	◯
Solve complex problems	◯	◯	◯	◯	◯	◯	◯

C. Social interaction	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Interact with the general public	◯	◯	◯	◯	◯	◯	◯
Ask questions or request assistance	◯	◯	◯	◯	◯	◯	◯
Accept instructions and feedback	◯	◯	◯	◯	◯	◯	◯
Get along well with others without distracting them	◯	◯	◯	◯	◯	◯	◯
Get along well with others without being distracted by them	◯	◯	◯	◯	◯	◯	◯

D. Adaptation	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Respond to frequent changes in the environment or tasks	◯	◯	◯	◯	◯	◯	◯
Aware of normal hazards and take appropriate precautions	◯	◯	◯	◯	◯	◯	◯
Travel in unfamiliar places or use public transportation	◯	◯	◯	◯	◯	◯	◯
Set realistic goals or make plans independently of others	◯	◯	◯	◯	◯	◯	◯
Juggle tasks and prioritize	◯	◯	◯	◯	◯	◯	◯

E. Responsibility and accountability	Yes	No
Is work pace without the pressure of deadlines?	◯	◯
Does the work involve occasional pressure to meet deadlines?	◯	◯
Does the work involve periodic pressure to meet deadlines?	◯	◯
Does the work involve significant pressures?	◯	◯

13 Other information

Please provide any additional information that you believe should be considered in assessing your claim.

14 When to contact Manulife Financial

NOTIFY MANULIFE FINANCIAL PROMPTLY IN THE FOLLOWING CASES.

I acknowledge I must notify Manulife Financial immediately if:

a) my medical condition improves, even though I have not yet returned to work,

b) I start work either as an employee or a self-employed person,

c) I apply for benefits under any workers' compensation law or plan as defined in Section 8,

d) I apply for benefits under Canada/Quebec Pension Plan,

e) I receive any benefits or income from any other source,

f) I am discharged from hospital if I am now hospitalized,

g) I receive any other benefits/income related to my disability.

h) I am leaving the country.

Plan member's signature

15 Agreement, authorization and certification

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 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)

[redacted]

Manulife Financial

Initial Attending Physician's Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of your patient's disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

Patient authorization

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 3 before it can be submitted to Manulife Financial.

What do we need from you?

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

Payment responsibility

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

Submitting forms

You may give the completed form to your patient or send it directly to Manulife Financial, Group Disability Benefits, at the address indicated below.

Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Tel: 1-800-465-2076
(416) 687-5049
Fax: (416) 687-5132
(416) 687-5211

Manulife Financial

Group Benefits
Initial Attending Physician's Statement
Group Disability Claim

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Plan contract number	Plan member certificate number

"I hereby authorize the release to Manulife Financial of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of this form.**"

Patient's signature	Date (dd/mmm/yyyy)

2 Attending physician's statement

Diagnosis

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) ***If*** psychiatric disorder, provide current GAF score.

GAF score

d) ***If*** cardiac disorder, provide American Heart Association functional classification.

◯ Class I (No limitation) ◯ Class II (Slight limitation)
◯ Class III (Marked limitation) ◯ Class IV (Complete limitation)

3 Clinical information

Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results in support of your patient's diagnosis and functional abilities.

a) What date did symptoms first appear/accident happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

◯ Injury ◯ Work-related ◯ Motor vehicle accident ◯ Other (specify)
◯ Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)	Date of latest visit (dd/mmm/yyyy)

Frequency of visits

◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Other (specify)

e) What are the patient's subjective ***symptoms***?

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity)

g) What were your initial ***clinical findings?***

h) What are your most recent ***clinical findings?***

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

◯ Ambulatory ◯ Bed confined ◯ Hospital confined
◯ Ambulatory with assistive devices ◯ Home confined

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand ◯ Left ◯ Right

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)

m) ***If*** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD OS	Without corrective lenses OD OS	Date of last exam (dd/mmm/yyyy)

n) ***If*** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

◯ Recovered
◯ Improved
◯ No change
◯ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

◯ Yes ◯ No

If no, please elaborate:

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

◯ Yes ◯ No ***If no, from what date?***

Date (dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

◯ Yes ◯ No

◯ Restricted ◯ Suspended ◯ Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.

Name of attending physician (please print)

Specialty

Telephone (include area code) ( )

Fax (include area code) ( )

Address (number, street and apartment)

City

Province

Postal code

Signature

Date signed (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 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.