Manulife

Group Benefits
Plan Member Statement
Critical Illness Claim

- To be completed by the employee.
- Please note section 5 - Certification, agreement and authorization may require the signature of the family member if your claim pertains to a family member.
- Please print clearly and answer all questions.
- **You are responsible for any fees your doctor charges for completion of the Attending Physician Statement form and photocopies of file documentation.**

Please submit this form to the appropriate address:

For English Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: group_disability_claims@manulife.ca

For French Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: groupe_invalidite@manuvie.ca

If sending by courier
Manulife
ATTN: GROUP LIFE CLAIMS
2000 MANSFIELD, SUITE 220
MONTREAL QC H3A 2Y8

1 Plan member information

Plan contract number: 136376
Plan member certificate number
Plan sponsor name
Preferred language: ◯ English ◯ French
Plan member name (first, middle initial, last)
Date of birth (dd/mmm/yyyy)
Address (number, street, apt.)
City
Province
Postal code
Telephone number ( )
Fax number ( )

Are you claiming for a family member? ◯ Yes ◯ No If *yes,* please provide:

Name
Relationship ◯ Spouse ◯ Child
Date of birth (dd/mmm/yyyy)

2 Claim information

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

1. Describe fully the nature and extent of the condition.

On what date was the condition diagnosed? (dd/mmm/yyyy)
If applicable, on what date was surgery performed? (dd/mmm/yyyy)

2. On what date was a medical practitioner first consulted in connection with the illness? (dd/mmm/yyyy)

Name of physician seen
Telephone number ( )
Physician's address

Was this the insured person's usual medical attendant? ◯ Yes ◯ No

If *no,* please provide the name and address of usual medical attendant

Name
Address

2 Claim information (continued)

3. On what date did symptoms first commence? (dd/mmm/yyyy)

Please describe these symptoms.

4. Were any tests or investigations undertaken? If *yes,* please provide details and dates.

5. Has the insured person previously suffered from, or received treatment for, a similar or related condition? If *yes,* please give full details and dates.

6. If this claim is as a result of an accident, please describe the incident and provide a copy of the police report.

3 Medical consultations

1. Name of usual physician

Address of usual physician

2. Please give details of any doctors or specialists who have been consulted in connection with the illness.

Name	Address	Date of consultation (dd/mmm/yyyy)

3. If there was any treatment at a hospital or similar institution, please supply the following information:

Name of hospital	City or town	Date of admission (dd/mmm/yyyy)	Date of discharge (dd/mmm/yyyy)

4. What other treatment was received and is currently being received in connection with the condition? (e.g., medications, therapy, etc.)

Type of treatment	Institution/Prescribing physician	Date (dd/mmm/yyyy)

4 General information

1. Has the father or mother or any of the brothers or sisters of the insured person ever suffered from a similar or related condition? If *yes,* please indicate:

Relationship	Nature of Illness	Date illness first diagnosed (dd/mmm/yyyy)

2. Is the insured person claiming for benefits related to this condition with another company? If *yes,* please indicate:

Name of insurer	Policy number	Type of benefit	Amount of benefit insured	Has claim been submitted?	Issue date (dd/mmm/yyyy)
			$	◯ Yes ◯ No	
			$	◯ Yes ◯ No	

3. Does the insured person use any form of tobacco, cannabis, nicotine products or nicotine substitutes? ◯ Yes ◯ No

If *yes,* please

Indicate amount per day	How long have these been used?

If *no,* did the insured person previously use any of these? ◯ Yes ◯ No

On what date did the insured quit? (dd/mmm/yyyy)

4. Please provide any further information which might be helpful in support of this claim.

5 Certification, agreement and authorization

I certify that the information in this form, and any further verbal or written statement in relation to this claim that is provided in the future, is true and complete to the best of my knowledge. **I agree** that this claim may be denied as a result of the provision of any false, incomplete, or misleading information. **I agree** to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, and **I authorize** Manulife to deduct such monies from any benefits payable as a result of this claim. **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 certify** that I am authorized to consent to the collection, use, maintenance, exchange, and disclosure of Information (as defined below) pertaining to any child under the age of sixteen (16) years who may be the subject of this claim for Critical Illness benefits, for the Purposes, defined below.

Plan member signature	Date (dd/mmm/yyyy)

To be signed by the person claiming for benefits. Plan member must sign if family member is under age 16.

I understand that Manulife will investigate this claim and may require personal information about me, including information regarding my activities, employment, health, and medical history and treatment, including clinical notes (collectively, the "Information"). **I authorize** any person or organization who has such Information, 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 disclose such Information to Manulife and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of this claim, including independent medical assessments (collectively, the "Purposes"). **I authorize** Manulife, 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 **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from the Plan Sponsor. **I understand** that any personal information provided to or collected by Manulife 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 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.

Claimant signature (plan member signature, if under age 16)	Date (dd/mmm/yyyy)

Manulife

Group Benefits
Request for Direct Bank Deposit

Please submit this form to the appropriate address:

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Direct Bank Deposit

Please complete this section in the event that benefits are approved.

Please attach a sample of a cheque for the account.
(Mark it void)

Plan contract numbers (include your plan member certificate number if this is a group policy)

Name of person(s) receiving payments		Social Insurance Number	
Address (number, street)	City	Province	Postal code
Name of financial institution			
Address (number, street)	City	Province	Postal code
Type of account ◯ Savings ◯ Personal chequing ◯ Current	Transit number	Bank account number	

I hereby authorize the Manufacturers Life Insurance Company ("Manulife") to deposit, until further notice, payments 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. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number.
The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Authorized signature	Date (dd/mmm/yyyy)

Print

Please attach your cheque sample marked "Void" here.