Manulife Group Benefits Life Claims

As a Plan Sponsor, complete page 1. You can print pages 2-10 and provide to the plan member or claimant for completion and submission to Manulife.

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 Nature of request

Please select the benefit type for which the claimant is applying.

◯ Death of the member ◯ Death of a dependent ◯ Death of a retiree ◯ Dismemberment

2 Plan sponsor's statement

This section should be completed by the plan sponsor. Declaration must be fully completed.

Plan contract number 136376 Division _____ Class _____ Union local, if unionized _____

Plan sponsor name The Boilermakers' National Health Fund (Car Plan sponsor contact name (first, middle initial, last) _____

Plan sponsor address (number, street, suite) _____ Phone number ( )

City _____ Province _____ Postal code _____

Email address _____

Plan member's name (first, middle initial, last) _____ Plan member's address (number, street, apt) _____

City _____ Province _____ Postal code _____

Date of birth (dd/mmm/yyyy) _____ SIN of plan member _____ Permanent employee ◯ Yes ◯ No

Plan member's employment start date (dd/mmm/yyyy) _____ Number of hours normally worked per week: _____ Plan member's last day worked (dd/mmm/yyyy) _____

Certificate number _____ Effective date of coverage (dd/mmm/yyyy) _____ Termination date of coverage, if applicable (dd/mmm/yyyy) _____

Was the plan member absent from work at the time of loss/death? ◯ Yes ◯ No Plan member occupation _____

If *yes,* what is the reason for absence from work: ◯ Sick leave ◯ Layoff ◯ Retired ◯ Leave of absence ◯ Other (please specify): _____

Plan member's salary at the last date worked $ _____ ◯ Annually ◯ Semi-monthly ◯ Bi-weekly ◯ Monthly ◯ Hourly ◯ Weekly

Effective date of salary (dd/mmm/yyyy) _____

Name of deceased/injured (first, middle initial, last) _____ Date of loss (dd/mmm/yyyy) _____

Beneficiaries

For plan sponsored administered group, provide a copy of the Plan Member Enrolment form/Beneficiary Designation form.

Beneficiary _____ Relationship _____ Date of birth (dd/mmm/yyyy) _____

Beneficiary _____ Relationship _____ Date of birth (dd/mmm/yyyy) _____

Please check claimed benefit(s) and specify amounts. For Plan Sponsor administered, submit copy of the Enrolment form for the plan member.

◯ Basic Life $ _____ ◯ Basic Accidental Death & Dismemberment $ _____ ◯ Paid Up Life $ _____

◯ Optional/Supplemental Life $ _____ ◯ Optional/Supplemental Accidental Death & Dismemberment $ _____ ◯ Dependent Life $ _____

◯ Other (please specify) _____ $ _____

Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Full name _____ Signature _____

Title _____ Date signed (dd/mmm/yyyy) _____

3 Claimant's statement

If the claimant is a minor beneficiary, the form must be completed on behalf of the minor beneficiary by an appointed trustee or guardian of the child or child's property, in the absence of an appointed trustee.

Instructions to claimant

Please indicate one of the situations below, and provide the required document(s).

Proceeds UNDER $300,000

◯ Provide original or copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

OR

◯ Attending Physician's Report (pages 5 and 6 of this form)

Proceeds $300,000 and OVER

◯ Original or copy of Provincial Death Certificate

OR

◯ Attending Physician's Report (pages 5 and 6 of this form)

Accidental Death

◯ Attending Physician's or Coroner's Statement (pages 7 and 8 of this form)

Accidental Dismemberment

◯ Attending Physician's Statement (pages 9 and 10 of this form)

Miscellaneous requirements

Payments to minor beneficiary

◯ Original or copy of Court appointment of Guardianship of the Estate of the Minor

Payments to estate

◯ Original or copy of the Probated Will or Letters of Administration for proceeds over $50,000.00

Beneficiary is deceased

◯ Copy of deceased Beneficiary's Proof of Death

Please submit this form and the required document(s) to the appropriate address:

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MONTREAL QC H3A 2Y8

Plan contract number 136376 Plan member certificate number _____

Plan member name (first, middle initial, last) _____

Please select the nature of the claim:

◯ Death - complete this section with information about the deceased.

◯ Dismemberment - complete this section about the insured member/dependent who sustained the injury.

Name (first, middle initial, last) _____ Marital status ◯ Married ◯ Single

Sex* ◯ Male ◯ Female ◯ Non-binary Date of birth (dd/mmm/yyyy) _____ Date of death/loss (dd/mmm/yyyy) _____

*Select male, female or non-binary (intersex) consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Address (number, street, apt) _____

City _____ Province _____ Postal code _____

If deceased/injured was a dependant child and attending school, name institution _____

At time of death/injury, was the dependent employed? ◯ Yes ◯ No If *yes,* indicate numbers of hours worked per week: _____

Please indicate cause of death or, if injury/death caused by an accident, please specify the date and the circumstances:

Claimant's name (first, middle initial, last) _____

Claimant's relationship to the deceased/injured _____ Claimant's date of birth (dd/mmm/yyyy) _____

Claimant's address (number, street, apt) _____

City _____ Province _____ Postal code _____

Claimant's primary phone number ( ) _____ Claimant's SIN _____

3 Claimant's statement (continued)

To be completed in case of a death claim.

Name of funeral home _____ Funeral home phone number ( )

I claim in the capacity of: ◯ Beneficiary ◯ Executor ◯ Legatee ◯ Heir ◯ Other (please specify) _____

By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

Claimant's email address _____

Claimant's signature _____ Date signed (dd/mmm/yyyy) _____

4 Direct deposit authorization

Please complete this section to consent to receiving benefits by direct deposit.

◯ **If depositing to a chequing account, please sign the authorization, and provide a copy of a void cheque in the area below.**

◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a bank verification statement.**

◯ **If the deposit is being made to an Estate, please complete the required information, sign the authorization and provide a bank verification statement/void cheque confirming the Estate account. Otherwise, proceeds will be paid by cheque.**

Name of financial institution _____

Address of financial institution (number, street, suite) _____

City _____ Province _____ Postal code _____

Type of account: ◯ **Chequing** ◯ **Savings** ◯ **Estate**

Branch or transit number (5 digits) _____ Institution number (3 digits) _____

Bank account number (maximum 12 digits) 010 _____

I hereby authorize Manulife to deposit, until further notice, payment 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.

Claimant's signature _____ Date (dd/mmm/yyyy) _____

Claimant's name (please print) _____

If providing a copy of a void cheque, please place it here.

5 Claimant's certification and authorization for all death and dismemberment claims

I certify that the information in this form is true and complete, to the best of my knowledge and belief. **I also certify** that any further verbal or written statement provided by me will be true and complete to the best of my ability. **I hereby** claim the group life insurance proceeds payable as a result of the death of the deceased.

Name of deceased/injured (first, middle initial, last) _____

I understand:

- that Manulife will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy, toxicology or coroners' reports.

I authorize:

- Manulife, its service providers, Manulife's reinsurers and its service providers, and any person or organization who has personal information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution and any other medically-related facility, insurer, police, coroner and investigative agency, to collect, use, maintain and disclose information for the purposes of group plan administration and audits as well as the assessment and investigation of this claim.
- the use of my Social Insurance Number (SIN) for the purpose of tax reporting.

I confirm:

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- that I understand that more specific details regarding how and why Manulife collects, uses, maintains, and discloses personal information can be found in Manulife's Privacy Policy, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or through the Plan Sponsor.

I acknowledge:

- 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 or disclosure of any 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 or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in the file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Claimant's signature _____ Date (dd/mmm/yyyy) _____

Claimant's name (please print) _____

Important - Please see instructions on Page 2 (Instructions to claimant) regarding the required document(s) prior to proceeding to pages 5-10.

Manulife

Group Benefits
Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant.
Please print clearly.

1 Plan member identification

Plan member's name (first, middle initial, last) _____ Certificate number _____

Plan contract number _____ Plan member's date of birth (dd/mmm/yyyy) _____

2 Physician's report

Deceased's name (first, middle initial, last) _____

Place of death _____

Date of death (dd/mmm/yyyy) _____ Age at death _____

If death occurred in an institution or hospital, please give name: _____

Residence address at death (number, street, apt.) _____

City _____ Province _____ Postal code _____

Cause of death *(Enter only one cause for each of a, b, and c.)*

Disease and condition directly leading to death:
(This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused the death).

Interval between onset and death

(a) _____ (a) _____

Antecedent causes:
(Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).

Interval between onset and death

Due to (b) _____ (b) _____

Due to (c) _____ (c) _____

To your knowledge, did the deceased ever smoke? ◯ Yes ◯ No ◯ I don't know If *yes,* how many years? _____ year(s)

Date of first attendance in last illness (dd/mmm/yyyy) _____

Date of last attendance in last illness (dd/mmm/yyyy) _____

If death was due to accident, suicide or homicide, specify which and describe briefly.

_____

Was an inquest held? ◯ Yes ◯ No Was an autopsy performed? ◯ Yes ◯ No

If *yes,* to either of the above, by whom and what findings?

_____

Continued on the next page.

2 Physician's report (continued)

Have you treated or advised the deceased during the last five years, prior to last illness? ◯ Yes ◯ No

Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution? ◯ Yes ◯ No

If *yes,* to either of the above, please provide the following information.

Name	Address	Nature of illness/injury	Approximate dates (dd/mmm/yyyy)

3 Attending physician's personal information

Attending physician's full name _____

Specialty _____

Address (number, street, suite) _____

City _____ Province _____ Postal code _____

Area code and phone number ( ) _____

Attending physician's signature

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by 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's signature _____ Date signed (dd/mmm/yyyy) _____

Submitting form

You may give the completed form to the claimant or send it directly to the appropriate address:

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2000 MANSFIELD, SUITE 220
MONTREAL QC H3A 2Y8

Manulife

Group Benefits

Attending Physician's or Coroner's Statement for Accidental Death

If there is a charge for the completion of this form, payment is the responsibility of the claimant.
Please print clearly.

1 Plan member identification

Plan member's name (first, middle initial, last) _____ Certificate number _____

Plan contract number _____ Plan member's date of birth (dd/mmm/yyyy) _____

2 Attending physician's or coroner's statement for accidental death

Deceased's name (first, middle initial, last) _____

Date of injury (dd/mmm/yyyy) _____

Date of death (dd/mmm/yyyy) _____

What was the precise nature and extent of the injury?

What was the primary or immediate cause of death?

Was the deceased ever treated for a similar condition? ◯ Yes ◯ No

If *yes,* where and by whom?

Were there any contributing or remote causes of death? ◯ Yes ◯ No

If *yes,* what were they?

Was the injury, described above, by itself and independent of all other causes, sufficient to cause death? ◯ Yes ◯ No

If *no,* please explain fully.

At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs? ◯ Yes ◯ No

If *yes,* please show blood alcohol content and type of drug.

Blood alcohol content _____ Type of drug _____

Was an autopsy performed? ◯ Yes ◯ No

Continued on the next page.

3 Attending physician's or coroner's personal information

Attending physician's or coroner's full name _____

Degree, qualification or specialty _____

Address (number, street, suite) _____

City _____ Province _____ Postal code _____

Area code and phone number ( ) _____

Attending physician's or coroner's signature

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by 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's or coroner's signature _____ Date signed (dd/mmm/yyyy) _____

Submitting form

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Manulife

Group Benefits

Initial Attending Physician's Statement – Group Accidental Dismemberment

If there is a charge for the completion of this form, payment is the responsibility of the claimant.
Please print clearly.

1 Patient authorization (To be completed by patient)

Patient's name (first, middle initial, last) _____

Plan contract number 136376 Plan member certificate number _____

I hereby authorize the release to Manulife 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's Privacy Policy and related materials on how and why Manulife collects, uses, maintains and discloses my personal information, is available upon request; on Manulife's website: www.manulife.ca, or through my Plan Sponsor.

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

2 Patient information

Patient's name (first, middle initial, last) _____

Patient's mailing address (number, street, apt.) _____

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 (number, street) _____

City _____ Province _____ Postal code _____

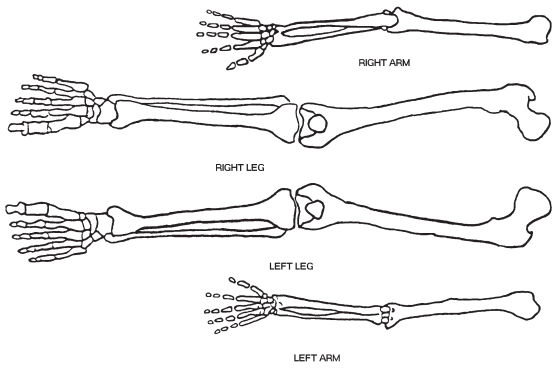
Details:

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 the next page.

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

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Attending physician's full name _____

Specialty _____

Telephone (include area code) ( ) _____ Fax (include area code) ( ) _____

Address (number, street, suite) _____

City _____ Province _____ Postal code _____

Attending Physician's signature _____ Date signed (dd/mmm/yyyy) _____

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