



MEMBER'S STATEMENT

1. Member's Name _____	2. Date of birth _____ Day Month Year	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
4. a) Address _____ b) Home Phone Number _____	5. Social Insurance No. _____	
	6. Name of attending Doctor (Please print) _____	
7. Date Total Disability commenced _____ Day Month Year	8. Date of expected return to work _____ Day Month Year	
9. If disability due to an accident, please indicate: a) Date and time of accident _____ at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Day Month Year b) Did accident occur at work? Yes <input type="checkbox"/> No <input type="checkbox"/> c) Brief description of accident. _____		
10. a) If confined to hospital: Name of hospital? _____ Date and time admitted _____ at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Day Month Year Date and time discharged _____ at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Day Month Year b) If examined and/or treated at emergency department but not confined to hospital: Name of Hospital? _____ Date and time seen _____ at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Day Month Year		

I/We certify that the statements provided by me are true and accurate to the best of my knowledge and belief.

I/We understand that Manulife Financial may investigate or review this claim. I/We authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, Workers' Compensation Board, group plan administrator, employer, policyholder or any other corporation, organization, institution, association or person to release and exchange any medical or benefit payment information or any other records requested by Manulife Financial to establish or review the validity of this claim.

I/We understand that this information will be maintained in a GROUP LIFE, HEALTH, and DISABILITY file with Manulife Financial. I understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information.

I/We authorize the use of my/our Social Insurance Number for the purpose of tax reporting and for the identification and administration of the Group Benefits.

I/We agree that a photocopy of this authorization shall be as valid as the original.

Signed this _____ day of _____, _____.

Signature of Member

CONTRACTHOLDER'S STATEMENT

1. Contractholder _____	Class Code _____	Group No. _____	Division No. _____
2. Member's Name _____	Social Insurance No. _____	Certificate No. _____	
3. Effective date of W.I. coverage _____ Day Month Year	4. If cancelled, please indicate: a) Date: _____ Day Month Year		
5. Date last worked _____ Day Month Year	b) Reason: _____		
a) Hours scheduled: from _____ <input type="checkbox"/> a.m. to _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> p.m.	Date returned to work _____ at _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Day Month Year		
b) Hours worked: from _____ <input type="checkbox"/> a.m. to _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> p.m.	6. Rate of Weekly Benefit this member is entitled to receive \$ _____		
7. Is claim being made for Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. What was member's Work Status at onset of disability? a) Working full time <input type="checkbox"/> b) Laid off <input type="checkbox"/> c) On leave of absence <input type="checkbox"/> } If (b), (c) or (d): d) On paid vacation <input type="checkbox"/> } From what date _____ to what date _____		
9. Brief description of job duties _____ _____ _____			
10. Have you any reason to question the validity of this claim or other information helpful to its processing? _____			
11. If applicable for tax purposes, please indicate a) Province in which member is taxed _____ b) Federal net claim amount \$ _____ c) Amount of Provincial exemption \$ _____			

NOTICE: By completing this employer's statement, information contained herein will become part of a GROUP LIFE, HEALTH and DISABILITY file with Manulife Financial and might be accessible by the employee or third parties to whom access has been granted or those authorized by law. By signing the statement, you consent to such unedited release of any information contained herein. An unsigned statement has no validity and cannot be considered for evaluation of any claim.

Authorized Signature _____	Date _____	Day _____	Month _____	Year _____
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Instructions

1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.

ATTENDING PHYSICIAN'S STATEMENT**Part 1: Patient Authorization**

	Policy No.
Name	Date of birth (<i>day, month, year</i>)
I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim. Patient's Signature	Date

Part 2. Attending Physician's Statement

1. Diagnosis of present condition

a) Primary

b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge

a) indicate when symptoms first appeared or accident happened (*day, month, year*)

b) has patient had same or similar condition

 No Yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment

 Yes No Unknown
4. If patient is/was pregnant indicate date or expected dated of confinement (*day, month, year*)5. Date of hospital in-patient admission (*day, month, year*)Date of discharge (*day, month, year*)6. Nature of treatment (*e.g. date and type of surgery*)

7. a) If patient was referred to you, give name of referring physician

b) If you have referred patient to a specialist, give name(s) of physicians

8. a) Date of first visit during present period of absence from work (*day, month, year*)b) Date of latest attendance (*day, month, year*)

c) Were you actively supervising this patient's care during the full period

 No, comments in remarks Yes, state frequency of visits Weekly Monthly Other (*specify*)

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition

From (*day, month, year*)To (*day, month, year*) inclusiveb) If still unable to work, give approximate date patient should be able to return (*day, month, year*)

the estimated number of weeks before possible return

or

10. Please advise how present condition affects patient's ability to work (*for example restrictions, limitations, proposed surgery, etc.*)

11. Remarks - Please provide comments and further details which you feel would be helpful

Name of attending physician (<i>please print</i>)	Specialty	Telephone No. () -
Address (<i>number, street, city, province, postal code</i>)		

NOTICE: By completing this physician's statement, information contained herein will become part of a GROUP LIFE, HEALTH and DISABILITY file with Manulife Financial and might be accessible by the patient through a designated health care professional of their choice, Manulife employees, or third parties as permitted by law. By providing the information herein, you consent to such unedited release of any information contained herein.

Signature	Date (<i>day, month, year</i>)
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