



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	5. Social Insurance No. [] [] [] [] [] [] [] [] [] []	
b) Home Phone Number	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 Day Month Year at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 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 Day Month Year at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Date and time discharged Day Month Year at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> b) If examined and/or treated at emergency department but not confined to hospital: Name of Hospital? Date and time seen Day Month Year at _____ A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>		
<p>I/We certify that the statements provided by me are true and accurate to the best of my knowledge and belief.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>I/We agree that a photocopy of this authorization shall be as valid as the original.</p>		
Signed this _____ day of _____, _____		X _____ Signature of Member

CONTRACTHOLDER'S STATEMENT		
1. Contractholder MOLSON COORS CANADA	Class Code	Group No. 85020 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 b) Reason: _____	
5. Date last worked Day Month Year	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 Day Month Year at _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 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"/> d) On paid vacation <input type="checkbox"/>	If (b), (c) or (d): 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. <u>85020</u>
Name	Date of birth (day, month, year)
I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim. Patient's Signature <u>X</u>	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 <input type="checkbox"/> No <input type="checkbox"/> Yes, please state when and describe
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3. Is condition due to injury or sickness arising out of patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	4. If patient is/was pregnant indicate date or expected dated of confinement (day, month, year)
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5. Date of hospital in-patient admission (day, month, year)	Date of discharge (day, month, year)
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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
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8. a) Date of first visit during present period of absence from work (day, month, year)	b) Date of latest attendance (day, month, year)
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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) inclusive
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b) 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
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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 (please print)	Specialty	Telephone No. () -
Address (number, street, city, province, postal code)		

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 (day, month, year)
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