

Group Benefits Sponsor Statement Group Disability Claim

- Please ensure to answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- This notification must be sent to Manulife without delay.

Please send this form to:

Manulife Group Benefits
 Attention: Disability Claims
 PO BOX 800, STN WATERLOO, Waterloo ON N2J 4C2
 Tel: 1-877-481-9169 or (519) 747-7000 Fax: 1-866-677-4215 or (519) 579-3680
 E-mail: group_disability_claims@manulife.com

1 Benefit application Please select the benefit type for which the plan member is applying:
 Short-term disability Long-term disability Waiver of premiums Critical illness Dismemberment

2 Plan sponsor information Plan contract number _____ Plan sponsor name _____

Street address (number, street, suite) _____

City _____ Province _____ Postal code _____

Plan sponsor contact name _____ Job title _____

Phone number _____ Fax _____ E-mail _____

Health centre contact and return work contact

If different from above, please indicate the person in the health centre involved in disability absences.

Name _____ Job title _____

Phone number _____ E-mail _____

If different from above, please indicate the person we should contact to facilitate a return to work once this employee's abilities and limitations are known.

Name _____ Job title _____

Phone number _____ E-mail _____

3 Plan member identification and work information Full name (first, middle initial, last) _____
 Date of birth (dd/mmm/yyyy) _____

Certificate number _____ Primary phone number _____ Alternate phone number _____

Class _____ Division _____ Job title _____

Permanent employee Yes No Date of hire (dd/mmm/yyyy) _____

Date for which the plan member was first covered under this plan. Date (dd/mmm/yyyy) _____

Has there been any interruption in the plan member's coverage? Yes No

Please indicate the **HOURS** of work in a normal week.

Is this shift work? Yes No

If yes, please indicate the work schedule or attach a copy of the work schedule.

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours of work each day							

Provide details if plan member's shift schedule is varied or rotational: _____

Is the member required to work night shift? Yes No

Plan member's gross salary as of the last day of work \$ _____ Per week Per month

Was the plan member: Salaried Hourly

What was the last date at work? Date (dd/mmm/yyyy) _____

3 Plan member identification and work information (continued)

Was this a full day/shift? Yes No

If no, how many hours were worked? _____ Is the absence work related? Yes No

What was the plan member's first missed day of work? Date (dd/mmm/yyyy) _____

Has the plan member returned to work? Yes No If yes, when? Date (dd/mmm/yyyy) _____

Did the plan member return to: Regular duties Modified duties

Tax Information - Please complete only if the benefit is taxable

TD1 code _____ TP1 code _____ Plan member's province of residence for income tax purposes _____

Is employment income tax exempt according to terms of Indian Act and Income Tax Act? Yes No If yes, please provide copy of TD1-IN.

Please indicate if any of the following have been paid (or are payable) since date plan member last worked

	Amount	Dates (dd/mmm/yyyy)	
Salary continuance	_____	From _____	To _____
Vacation	_____	From _____	To _____
Sick Leave	_____	From _____	To _____
Severance	_____	From _____	To _____
Employment Insurance benefits	_____	From _____	To _____
Other * _____ (please indicate the source)	_____	From _____	To _____

*E.g. Short-term disability benefits, commissions or bonuses, retirement pension. If more space is needed, please use a separate sheet of paper.

4 Life coverage To be completed for self-administered groups applying for waiver of premium or please provide a copy of the Enrolment Application.

Group Life Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Annual salary \$ _____ Date of last increase (dd/mmm/yyyy) _____

Life coverage when last actively at work Terminated Active Suspended

Amount of Life coverage

Basic \$ _____ Spousal \$ _____ Dependent Children \$ _____
 Optional \$ _____ Optional Spousal \$ _____ Other _____ \$ _____
(specify)

Group Accidental Death and Dismemberment Benefit (AD & D)

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of AD & D coverage

Basic \$ _____ Optional \$ _____ Spousal \$ _____ Optional Spousal \$ _____

Group Survivor Income Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Monthly survivor benefit amount \$ _____ Type of coverage Spousal Spousal and children Other (specify) _____

Critical Illness Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of Critical Illness Benefit

Plan member basic \$ _____ Plan member optional \$ _____ Spousal \$ _____ Child \$ _____

5 Declaration

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

Name _____ Title _____

Signature _____ Date (dd/mmm/yyyy) _____

Please ensure section 6 is completed by the plan member's supervisor.

6 Occupational information This section may be separated from the rest of the form if necessary. Please attach a physical demands analysis if available.

Completed by:

Name and title _____ Date completed (dd/mmm/yyyy) _____

What was the plan member's occupation immediately prior to the plan member stopping work? _____

Were the plan member's duties and/or hours modified from their regular occupation? Yes No If so, when? (dd/mmm/yyyy) _____

Please describe this plan member's regular duties (or attach a copy of the company's job description) as well as any modifications, if any. _____

7 Occupational demands The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the frequency for which the following activities are regularly performed:

Activity	N/A	INFREQUENT	FREQUENT	CONSTANT
		0-33% of the workday	34-66% of the workday	67-100% of the workday
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving / Operating machinery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing up and down the stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does the employee's occupation require repetitive movements? <input type="radio"/> Yes <input type="radio"/> No				

Activity	N/A	INFREQUENT	FREQUENT	CONSTANT	Pushing/ Pulling	N/A	INFREQUENT	FREQUENT	CONSTANT
		0-33% of the workday	34-66% of the workday	67-100% of the workday			0-33% of the workday	34-66% of the workday	67-100% of the workday
Lifting 0-10 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	0-10 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting 11-20 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting 11-20 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting 21-50 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting 21-50 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting 51-100 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting 51-100 lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting 100+ lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting 100+ lb.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does the plan member use a lifting device? <input type="radio"/> Yes <input type="radio"/> No									

Activity	Definition	N/A	INFREQUENT	FREQUENT	CONSTANT
			0-33% of the workday	34-66% of the workday	67-100% of the workday
Understanding and memory	Understanding and remembering instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sustained concentration	Maintaining attention and concentration for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social interaction	Interaction with co-workers and/or the general public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adaptation and multitasking	Response to frequent changes, juggle tasks and prioritizes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meeting deadlines	The work involves time pressure and deadlines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responsibility and accountability	Errors in judgement or attention can have significant consequences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Name _____ Title _____

Signature _____ Date (dd/mmm/yyyy) _____

Please note: The information in this statement will be kept in a group life, health or disability benefits file with Manulife and might be accessible by the plan member 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.