

Group Benefits

Plan Member/Dependent Statement

Accidental Dismemberment Claim

INSTRUCTIONS

If a dependent claim is made, please fill out all sections relevant to the dependent.

Plan sponsor statement - To be completed by plan administrator (page 1).

Plan member statement - To be completed by plan member (page 2).

Attending physician's statement - To be completed by attending physician (page 3).

• Please print all answers.

• To avoid delay in the processing of the claim, please ensure that every question is answered.

• The plan member is responsible for the completion of this form without expense to Manulife Financial.

1 Plan sponsor statement for plan member accidental dismemberment

Plan number(s)		Account/Division number	Certificate number
Plan sponsor's name		Employer's name (if different from plan sponsor)	
Plan member's name (last, first, middle initial)		Date of birth (dd/mmm/yyyy)	Occupation of plan member
Status of plan member <input type="radio"/> Full time <input type="radio"/> Part time	Date of employment (dd/mmm/yyyy)	Date last worked (dd/mmm/yyyy)	Salary effective date (dd/mmm/yyyy)
Regular no. of hrs. worked/ week	Amount of insurance \$	Current salary \$	<input type="radio"/> Annually <input type="radio"/> Monthly <input type="radio"/> Semi-monthly <input type="radio"/> Bi-weekly <input type="radio"/> Weekly <input type="radio"/> Hourly

Is the injury work related? Yes No

If "Yes", has claim been filed with any type of workers' compensation board? Yes No

Was plan member:

Retired Temporary layoff Disabled Leave of absence

Date of termination (if applicable)
(dd/mmm/yyyy)

If plan member was disabled, was any claim for disability benefits filed during this period? If "Yes", please provide claim number and name of carrier. Yes No

Claim number	Name of carrier
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According to your records, on the date of the accident had the plan member/dependent fully satisfied the eligibility requirements for dismemberment insurance under this plan? Yes No

Dependent information

(To be completed if a dependent claim is made.)

Dependent's name (last, first, middle initial)	Relationship to plan member	Date of accident (dd/mmm/yyyy)
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Amount of dependent insurance
\$

Is dependent spouse insured at non-smoker rates? Yes No

If "Yes", please attach copy of declaration.

Do you know any reason why this claim should not be paid? Yes No

If "Yes", please give details.

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For plan sponsor administered plans only

Please submit a COPY of the enrolment form for this plan member.

Plan member's insurance class (if applicable)	Most recent effective date of plan member's coverage (dd/mmm/yyyy)	Original effective date of dependent coverage (dd/mmm/yyyy)	Date to which premiums were paid (dd/mmm/yyyy)
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2 Declaration

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

Plan sponsor signature	Date (dd/mmm/yyyy)	Plan sponsor phone number	
Plan sponsor mailing address (number, street)	City	Province	Postal code

The information in this statement will become part of a group life and health benefits file which might be accessible by the plan member or third parties to whom access has been granted or those authorized by law.

3 Plan member statement

Plan member's mailing address (number, street)		City	Province	Postal code
Social Insurance Number	Date of birth (dd/mmm/yyyy)	Date of accident (dd/mmm/yyyy)	Time of accident <input type="radio"/> A.M. <input type="radio"/> P.M.	

Please provide details of the occurrence, such as where, when and how it occurred.

Witness's name (last, first, middle initial)				
Witness's mailing address (number, street)		City	Province	Postal code
Attending physician's name			Date of first visit to attending physician (dd/mmm/yyyy)	
Attending physician's address (number, street)		City	Province	Postal code

Dependent information (To be completed if a dependent claim is made.)

Dependent's mailing address (number, street)		City	Province	Postal code
Date of birth (dd/mmm/yyyy)	Marital status <input type="radio"/> Married <input type="radio"/> Single	Relationship to plan member		
Date of accident (dd/mmm/yyyy)	Time of accident <input type="radio"/> A.M. <input type="radio"/> P.M.			

Was the accident work-related? Yes No

Was the dependent confined to a hospital when coverage became effective? Yes No

If "Yes," indicate date discharged

(dd/mmm/yyyy)

If claiming for a dependent child who is attending school, name institution:

Institution

Was he/she dependent on you for financial support? Yes No

At the time of the accident, was the dependent employed? Yes No

If "Yes," indicate number of hours worked per week

No. of hours	Name of dependent's employer
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Please provide details of the occurrence, such as where, when and how it occurred.

4 Assignment, certification and authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I understand Manulife Financial may investigate this claim. I authorize any plan sponsor, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, the Medical Information Bureau, any type of workers' compensation board or commission, group plan administrator, or any other corporation, organization, institution, association or person to release and exchange with Manulife Financial any medical or benefit payment information, or any other information or records that may be requested by Manulife Financial to process this claim. If my Social Insurance Number is used as my certificate number, I authorize its use for the identification and administration of my group benefits. I agree that a photocopy of this authorization shall be as valid as the original.

Plan member's signature	Date signed (dd/mmm/yyyy)
Spouse's signature	Date signed (dd/mmm/yyyy)

If claim for spouse, please have spouse sign and date.

At Manulife Financial, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to this information will be limited to:

- our employees and service representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.

Group Benefits Initial Attending Physician's Statement Group Accidental Dismemberment

Please print clearly.

1 Patient authorization

(To be completed by patient)

Patient's name (last, first, middle initial)	Plan number	Certificate number
I hereby authorize the release, to my insurer, of any medical information in my file, including copies of hospital records, with respect to this claim. I understand I am responsible for any fees related to the completion of this form.		
Patient's signature	Date (dd/mmm/yyyy)	

2 Patient information

Patient's name (last, first, middle initial)			
Patient's mailing address (number, street)	City	Province	Postal code
Date of injury (dd/mmm/yyyy)	Date of first attendance for present injury (dd/mmm/yyyy)		
Was injury caused while the patient was employed? <input type="radio"/> Yes <input type="radio"/> No			
Please describe the injury.			
If treated at hospital, please give name, address and details.			
Hospital	Address of hospital		
Details			
Was the injury described solely responsible for the loss? <input type="radio"/> Yes <input type="radio"/> 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 back

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 Physician's declaration

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 you consent to such unedited release of any information contained herein.

Attending physician (please print)

Certified specialist

Telephone (include area code)

()

Address (number, street, city, province, postal code)

Fax (include area code)

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Physician's signature

Date signed (mmm/dd/yyyy)

Submitting form

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

If you live outside Quebec:

Manulife Financial
Waterloo Group Life Claims Office
PO BOX 1629
WATERLOO ON N2J 4P6

If you live in Quebec:

Manulife Financial
Montreal Group Life Claims Office
PO BOX 395 STN PLACE D'ARMES
MONTREAL QC H2Y 3H1