Manulife Financial

Weekly Income Statement of Claim

Member – complete this section. Please print.

GROUP POLICY NO. 901884 SHEET METAL WORKERS (LOCAL 30) WELFARE PLAN

1. Member's Name ______________________ Date of Birth ___/___/___ (Day Mo. Year)
2. Address ______________________ (Street) ______________________ (City) S.I.N. [| | | | | | | |]
   ______________________ (Province) Postal Code ______________ Phone No. ______________
   Lodge ______________________
3. On what date were you first disabled and unable to work? ___/___/___ (Day Mo. Year) at ________ ☐ A.M. ☐ P.M. On what date do you expect to return to work? ___/___/___ (Day Mo. Year)
4. Is disability due to an accident? ☐ NO ☐ YES If "YES", please answer the following questions.
   (a) When did it happen? ___/___/___ (Day Mo. Year) Time ____________ ☐ A.M. ☐ P.M.
   (b) Where did it happen? ☐ at work ☐ at home ☐ elsewhere (name place) ______________________
   (c) How did it happen? ______________________
5. On what date were you first treated by a physician for this disability? ___/___/___ (Day Mo. Year)
6. List names and addresses of physicians who have treated you in connection with this disability.
   ____
   ____
7. Have you been hospitialized in connection with this disability? ☐ NO ☐ YES If "YES", please indicate:
   Name of Hospital ______________________ Dates Hospitalized: FROM ___/___/___ (Day Mo. Year) TO ___/___/___ (Day Mo. Year)
8. Are disability benefits payable from any other source as the result of this sickness or injury? ☐ NO ☐ YES
   If "YES", give name of source. ______________________

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be declined or terminated as a result of my providing false, incomplete or misleading information. I authorize Manulife Financial and/or its authorized representative to collect, use and disclose personal information regarding me and/or my dependants (where applicable) for the purpose of determining eligibility for Manulife Financial products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife Financial's Privacy Policy and Policy Information Package, available at www.manulife.ca or by request.
I authorize Manulife Financial and/or its authorized representative to conduct such investigation concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Manulife Financial and/or its authorized representative will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This insurance that I may have with Manulife Financial, the provision of rehabilitation assistance to me, assisting me in returning to work, administering the policy under which my claim has been made, and medical case study or review. I therefore authorize Manulife Financial and the following persons, institutions and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control; any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, and investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information. I understand that any Personal Information that I provide or which Manulife Financial and/or its authorized representative has collected, will be kept in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife Financial and other persons (corporate or individual), firms or agencies engaged by Manulife Financial, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law. I understand that where Manulife Financial and/or its authorized representative has obtained sensitive medical information from someone other than my physician, Manulife Financial will only release such information through my physician.
I hereby authorize the use of my Social Insurance Number (SIN) for the purposes of administering this claim and for tax reporting identification purposes. I understand and agree that this authorization shall continue so long as the claim for which this authorization has been completed exists, or services for this claim are required by Manulife Financial and/or its authorized representative. A copy of this authorization shall be as valid as the original.

Member's signature ______________________ Date ______________

Member - Send completed claim form to:

Employee Benefit Plan Services Ltd.
45 McIntosh Drive
Markham ON L3R 8C7
Telephone: (905) 946-9700
1-800-263-3564

Attending Physician's Statement

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.

Part 1: Patient Authorization

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 | Date (day, month, year)

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 day 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 (eg. date and type of surgery, treatment including medication, dosage and frequency)
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 and all subsequent visits during present period of absence from work (day, month, year)
   b) Were you actively supervising patient's care during full period ☐ No-comment in remarks ☐ Yes, state frequency ☐ 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)
   b) If still unable to work, give approximate date patient should be able to return (day, month, year) or the estimated number of weeks before possible return
10. How does present condition affect patient's ability to work (for example, restrictions, limitations, proposed surgery, etc.)
11. Do you believe patient is competent to endorse cheques and direct the use of the proceeds thereof? ☐ Yes ☐ No
12. Remarks - Please provide comments and further details which you feel would be helpful.

Name of the attending physician (please print) | Speciality | Telephone No. ( )

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

Signature | Date (day, month, year)