Member Statement

- Long Term Disability Claim
- Waiver of Premium Claim for:
 - Basic & Optional Life Benefit
 - AD&D Benefit
 - Survivor Benefit

An incomplete form may result in delays in the adjudication of your disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your plan sponsor and your physician(s).

We ask you to provide information about what you are capable and incapable of doing, in relation to your job demands.

We ask your plan sponsor to tell us about your job demands.

We ask your physicians to provide us with information about your restrictions and limitations.

You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.

All of the above information will be reviewed to determine whether you meet the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Instructions for this form

Please complete all sections of this form, sign and date it, and return it to your plan administrator for submission to Manulife Financial (or; if you prefer, you can submit it directly to Manulife Financial, Group Disability Benefits, at the address below).

This form must be fully completed by the plan member and submitted no later than 6 weeks prior to the expiration of the Long Term Disability Qualifying period.

Authorization to attending physician

Please complete, sign and date the "Patient authorization" section at the top of page 3 of the Attending Physician's Statement form before you take it to your physician.

Our approach

Manulife Financial is committed to timely and effective return to work whenever possible. Should your claim for LTD benefits be accepted, we will review your situation and a representative of Manulife Financial will contact you to explore your current circumstances, and, if appropriate, develop a plan for your return to work.

Any questions?

Your plan administrator is the best person to answer any questions you may have about your LTD benefit plan or the application process.

Manulife Financial Group Benefits Attention: Disability Claims PO BOX 4606 STN A TORONTO ON M5W 4Z2 Tel: 1-800-465-2076

(416) 687-5049 Fax: (416) 687-5132

(416) 687-5211

Group Benefits Member Statement Group Disability Claim

Additional information may be submitted on separate pages if there is insufficient space on this form.

1	Plan member information	Plan sponsor's name		Plan contract number	Division n	0.	Plan m	nember certificate numbe	er	
	You can obtain your plan	S.I.N.	Job t	itle	ntraffice measurature (commune e e e e e e e e			van dat uit voorge der uit des einstellen voor de despektele de en de de de verde vergelende de en de de de de	garcini	
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2	Work information a) Last day worked?	(dd/mmm/yyyy)							The state of the s	
	b) Prior to stopping work had your job been modified?	O Yes O No If yes,	, how w	vas it modified?						
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	If your work was modified, why were you unable to continue working?		reagness conscious contraction		ouzzoorkomia schoolield Ardinikryk dakst	Scheriffen von Stock war der verwerkelt ist de der eine eine eine	i dik Umikarit di Addistrim (Lisan			
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		e work absence menced:			
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		s work absence due to n injury?	Yes No If no, please	go to section 6, Illne	ess information.
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		escribe how and when njury occurred.			
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			Date of injury (dd/mmm/yyyy)	Time of injury a.m	
		there any legal action	Yes No If yes, please	provide lawyer's na	ame and address.
	(n	ot required if claim is for aiver of premium benefit only)	Lawyer's name	Lawyer's address	
			Phone number	Principal Supervision II Les cuant 2.1/il landurat canacido de Secrit de caracter es intra és secios de Principal Supervision II Les cuant 2.1/il landurat canacido de Secrit de caracter es intra és secios de la caracter de la cara	
	in - ; (n	Vas the occurrence investigated by police? of required if claim is for aiver of premium benefit only)	Yes No If yes, please	provide a copy of t	he police report.
5		or vehicle accident rmation	(not required if claim is for waive		t only) nce adjuster's name and phone number
	re a	your work absence is elated to a motor vehicle ccident, please provide ne following information:	Your insurance policy number or claim n	umber	
6	Illne	ss information			
		ave you ever had the ame or a similar illness?	Yes No If yes, state v	when and describe.	If no, go to section 7, Medical information.
		id the illness result in an bsence from work?	Yes No If yes, state v	vhen.	
			From (dd/mmm/yyyy)	To (dd/mmm/yyyy)	
	co it	escribe your current ondition, including how prevents you from orking.			

7 Medical information

- a) Please provide the following information about the family doctor who has your MEDICAL RECORDS.
- b) Please provide the following information about ANY OTHER SPECIALIST OR HEALTH CARE PRACTITIONER you have seen or are scheduled to see for this condition. (e.g. chiropractor, physiotherapist, psychologist, etc.)

Last name of docto	r First nam	ne of doctor	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
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Postal code	Telephone number		Type of practitioner	$eq:control_co$

8 Income/Benefit information

Have you received or are you receiving any of the following income/benefits.

If so, please provide copies of pay slips and/or award letters, including decline letters.

(not required if claim is for waiver of premium benefit only) Receipt of any benefits, including the following may result in a reduction to the benefit you receive from Manulife Financial and may require reimbursement to Manulife Financial of any benefit paid under this claim. It is imperative that you notify us of any change in the status of these benefits.

INCOME/	DATE OF	REFERENCE		CURRENT	STATUS: (Che	ck all that apply)	
BENEFIT	APPLICATION (dd/mmm/yyyy)	OR CLAIM NUMBER	PENDING?	AWARDED?	DECLINED?	TERMINATED?	APPEALED
QPP			0	0	0	0	0
CPP/S.S.B.		2000 100 00 00 00 00 00 00 00 00 00 00 00	0	0	0	0	0
Workers' compensation*	CAT CONTROL AND	amanmanina menena m	0	0	0	0	0
Other group nsurance	The second control of the second seco	\$1000000000000000000000000000000000000	0	0	0	0	0
Association plan	Service of the servic			0		0	0
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Creditor's disability				0	0	0	O
Employment	American constitution of the state of the st		10			. O	With the street of the street
Any other Manulife plan			0	0	PERTONIA DE CONTRACTOR CONTRACTOR DE CONTRAC		

^{*}Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission de la santé et de la sécurité du travail (CSST).

9 Summary of education, training and experience

Please attach a copy of a current résumé, if available. Otherwise, please provide the following information.

a) Education

b) Work experience

Begin with most recent but include every job you have had in the last 15 years. If more space is required, please use additional sheets of paper.

SCHOOL	LOCATION	LEVEL OBTAINED	YEAR	AREAS OF STUDY
Elementary school/ High school				Management of the Control of the Con
College or university				
Other		THE THE PARTY OF STATES OF SHIPTS DO SECTION DEPOSITS CONTRACTOR SECTIONS	Service Sear Money and Proposition of Service Search Searc	
(Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.)				Facility Annual Commission of

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,	c) Acquired skills If not already mentioned										
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	and the second s			40.00							
	Driver's license information										
	a) Does your job require you to have a professional license or designation? Please explain. b) Payer have a relid.										
	b) Do you have a valid driver's license?		Class	S No	Indic	ate any restr	rictions		And the Control		
11	Other interests					150 E. S.					
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İ	including any volunteer	work.									
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12	Work capacity evalu	uation	indicate	the extent the ETO DO", p	nat you are	now able t	o perform eac	job duties and you h activity that you	r job req	puires. If you have	ve indicated
	Activity	N/A	SELDOM (<1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2-4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (>6 hrs.)	UNABLE TO DO (Please explain)			
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	Are you able to work in any of the	ne follo	wing con	ditions?	Yes	No		lf "No", please explain
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	A. Understanding and memory	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Remember locations and routine procedures							
	Understand and remember short and simple instructions	0	0	0	0	0	0	
	Understand and remember detailed instructions	0	0	0	0	0	0	
	B. Sustained concentration and persistence	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Carry out short and simple instructions	0	0		SERVICON CONTROL MANAGEMENT AND A SERVICE OF		0	
	Carry out detailed instructions	\circ	0	0	0	0	0	0
	Maintain attention and concentration for extended periods	0			<u> </u>	0		
	Perform activities within a schedule	0	0					
	Sustain an ordinary routine without supervision	0			ectoriza nonezanta ne sinezon quintza p			
	Make simple decisions	0	0	0	0	0	0	
Si	Solve simple straightforward problems	0						
CTIVITIE	Solve complex problems	0	0	0	0	0	0	
ACTI	C. Social interaction	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
£ .	Interact with the general public	0				0		
YCHOLOGICAL	Ask questions or request assistance	0			0	0		
<u>0</u>	Accept instructions and feedback	0	0	0		0	0	
ζ	Get along well with others without distracting them	0	0	0			0	
PS	Get along well with others without being distracted by them	0	0	0	0	0	0	0
	D. Adaptation	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
	Respond to frequent changes in the environment or tasks	0	0	0	0	0	0	0
	Aware of normal hazards and take appropriate precautions	0	0				0	
	Travel in unfamiliar places or use public transportation	0	0				0	
	Set realistic goals or make plans independently of others	0				0		
	Juggle tasks and prioritize	0	0	0	0	0	0	
	E. Responsibility and accountal	bility			11.2	Yes	No	
	Is work pace without the pressure of de	s work pace without the pressure of deadlines?					O CONTRACTOR CONTRACTO	
	Does the work involve occasional pres	sure to r	meet deadli	nes?				
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n results	Does the work involve significant press	sures?			100 m	0	0	

13 Other information

Please provide any additional information that you believe should be considered in assessing your claim.

14 When to contact Manulife Financial

NOTIFY MANULIFE FINANCIAL PROMPTLY IN THE FOLLOWING CASES.

I acknowledge I must notify Manulife Financial immediately if:

- a) my medical condition improves, even though I have not yet returned to work,
- b) I start work either as an employee or a self-employed person,
- c) I apply for benefits under any workers' compensation law or plan as defined in Section 8,
- d) I apply for benefits under Canada/Quebec Pension Plan,
- e) I receive any benefits or income from any other source,
- f) I am discharged from hospital if I am now hospitalized,
- g) I receive any other benefits/income related to my disability.
- h) I am leaving the country.

Plan member's signature

15 Agreement, authorization and certification

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I agree to refund any monies that I may owe to Manulife Financial in accordance with the provisions of the group benefits plan with Manulife Financial, and I authorize Manulife Financial to deduct such monies from my group benefits.

Manulife Financial will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.

I authorize any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency, to release my personal information to Manulife Financial and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize Manulife Financial, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I understand that information relating to Manulife Financial's Privacy Policy, which includes information on how and why Manulife Financial collects, uses, maintains and discloses my personal information, is available upon request; on Manulife Financial's Web site: www.manulife.ca, or through my Plan Sponsor.

I understand that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs;
- · Persons to whom I have granted access; and
- · Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Plan member's signature

Date signed (dd/mmm/yyyy)

Initial Attending Physician's Statement

- Long Term Disability Claim
- Waiver of Premium Claim for:
 - Basic & Optional Life Benefit
 - AD&D Benefit
 - Survivor Benefit

An incomplete form may result in delays in the adjudication of your patient's disability claim.

Please see page 2 for instructions.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

Patient authorization

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 3 before it can be submitted to Manulife Financial.

What do we need from you?

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

Payment responsibility

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

Submitting forms

You may give the completed form to your patient or send it directly to Manulife Financial, Group Disability Benefits, at the address indicated below.

Manulife Financial Group Benefits Attention: Disability Claims PO BOX 4606 STN A TORONTO ON M5W 4Z2

Tel: 1-800-465-2076 (416) 687-5049

Fax: (416) 687-5132 (416) 687-5211

Group Benefits Initial Attending Physician's Statement Group Disability Claim

1	Pa	tient authorization	Name (last, firs	st, initial)		Plan contract number	Plan member certificate number
	То	be completed by patient.	not limited to	o, copies of all con administering the g	sultation reports, clin	ical notes, test results sing my claim. I under	nation in my file including, but and hospital records, for the stand that I am responsible
			Patient's signat	ture		Da	ate (dd/mmm/yyyy)
2		tending physician's atement					
	Di	agnosis		COMPANIENT PROPERTY OF THE PRO			
	a)	Primary diagnosis:					
	b)	Additional diagnoses or complications:					
	c)	If psychiatric disorder, provide current GAF score.	GAF score				
	d)	If cardiac disorder, provide American Heart Association functional classification.	Class II	(No limitation) (Marked limitation)	<u>~</u>	ight limitation) omplete limitation)	
3	CI	inical information	provide cop	ies of any chart r	ur help to identify yo notes and test resul	our patient's function ts in support of your	al capabilities. Please patient's diagnosis and
	a)	What date did symptoms first appear/accident happen?	functional a				
	b)	When did your patient's condition begin?	(dd/mmm/yyyy)			
	c)	Is this condition due to:	O Injury O Illness	○ Work-related	Motor vehicle acc	sident Other (spe	cify)
	d)	What is the date of the first visit, the latest visit and the frequency of visits?		sit (dd/mmm/yyyy)	Date of latest	visit (dd/mmm/yyyy)	11 Carical Co. (1988)
			Frequency of v Weekly	risits Bi-weekly	O Monthly	Other (specify)	
	e)	What are the patient's subjective <i>symptoms</i> ?	Weekly	Di-Weekiy	Montuny	Outer (specify)	
	f)	How have symptoms evolved to date? (Please indicate frequency and severity)					

g) What were your initial clinical findings?							
	The control of the co		GOOGNA-ROTHT INNINNA UAILMINUSER LARUMINISTA	AND STATE OF THE PROPERTY OF T	elleri i il tratoj-kari i repor e servizione lateratura servizione della compressione della compressione della		
h) What are your most recent clinical findings?							
			ervening und military anthory our Military and Part State (1995).				epengaman Andri stoken gi ayang an an arang grego sang an epengang sa tabung senta a sa senaman
		and and a support distabilities for a conditional of the	skizankovizatitih sukleovuk yek zadartikar zankove y 15-45 fi, ka ega zaz-y				
i) Restrictions and limitations							
(i) Please comment on any physical limitations arising from this							
condition, including such activities as lifting, walking,			en e consultat de la consultat			100 U 444 TO U 444 C 100 H 100 F U 544 C 100 F U 5	
standing, kneeling, sitting, repetitive			Z CONTROLOGIS E LO ALIZENTA POR ESTANOSTICA E CINERASTINO PORTURA E CONTROLOGIS POR PORTURA E CONTROLOGIS PORTUGA E CONTROLOGIS PORT			et descrippingstaten en e	enna umana unes senenci di arrendi ra su spishomonya Apres fisa. 1628 sobri 625
movements, carrying, and so forth.							
(ii) Please outline any cognitive or psychiatric limitations arising from							
this condition, as they relate to activities such as the following: understanding and				ERNÍ ON SEEMINISTELLAN POR OUR A PERALENCI CHISTININI	nggunau, neggyuyan chibe di hersoti. Nadalandi co		
memory, sustained concentration, social interaction, ability to		destination of a fact of the section	ng pag-panak kita penganag kita pengantan seber-pengan pang-penganan pabenan		BERRION A CASCAGNICA HARP AND DELICATED SPECIALISM AND THE AMERICAN DEPOSITION OF	A PRACTICAL CONTRACTOR A CONTRACTOR AND ACTUAL CONTRACTOR ACTUAL ACTUAL CONTRACTOR ACTUAL ACTUAL CONTRACTOR ACTUAL ACT	муся с на при том на населения по за населения по том и по селения по селения по селения по селения по селения
work to deadlines, ability to accommodate change, and so forth.						d a section in Gold Carlot and Carlot Car	
		CONTROLLER TO A PROPRESSION OF UNCORNEY OF PROPRESSION OF THE SECURITIES OF THE SECU					
j) Is your patient:	○ Ambulatory		O Bed conf	fined	O Hospital o	onfined	
	Ambulatory with assistive d	levices	O Home co	onfined			
k) What is the patient's current height and weight, and dominant hand?	Current height		Current weigh	nt		Dominant har	nd Right
 If patient is hypertensive, provide the last 3 blood 	Reading		Date read (dd/r	mmm/yyyy)			
pressure readings.	Reading	likaj kandralistik da milijoninė tempori sude sukinarinis tyrotyde ira syymmys apod	Date read (dd/r	mmm/yyyy)			
	Reading	aaakunuuttiisteen ja ja jallineen mohillilija stateejeste hoomuuta kat	Date read (dd/r	mmm/yyyy)			
 m) If patient is visually impaired, provide vision and date of last examination. 	With corrective lenses OD OS	Without correct OD	ctive lenses OS	Date of last e	xam (dd/mmm/yy	уу)	
n) If patient is pregnant, give date of EDC.	Date of EDC (dd/mmm/yyyy)						

Tr	eatment	N/	AME OF PRAC	TITIONER		TYPE OF P	RACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)		
a)	Names of other treating/consulting physicians or health care practitioners:									
b)	Current medications			DOSAGE	DURATION	START DATE (dd/mmm/yyyy)		ESPONSE		
c)	Other forms of treatment or therapies			DUR.		START DATE (dd/mmm/yyyy)				
d)	Hospitalizations:	ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE (dd/mmm/)	DATES yyyyy)	FACIL		(date of sur	EASON gery if applicable)		
e)	Treatment response:	Recovered Improved No change Retrogressed	Comments							
f)	Is your patient following the recommended treatment program?	Yes No No	If no, plea	ase elabo	rate:					

	g) Details of any <i>proposed</i> changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:									
5	Competency Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?	O Yes O No If no, from what date? Date (dd/mmm/yyyy)								
6	Licence restriction Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?	Yes No Restricted Suspended Revoked Type of licence If yes, when will your patient be eligible to Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy) Class of licence (if applicable apply for reinstatement		he licenc	ce or certification?				
7	Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.									
		Name of attending physician (please print)								
		Specialty	Telephone (include area co	ode)	Fax (inclu	ide area code)				
		Address (number, street and apartment)		oomooldeen kke versen siirii zala (Siida)	in the Continue of the Continu					
		City		Province	•	Postal code				
		Signature		Date sign	ned (dd/mm	nm/yyyy)				
		The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by the patient 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.								