Manulife Financial

For your future™

APPLICATION FOR WEEKLY DISABILITY BENEF

EMPLOYER STATEMENT OF CLAIM

Employer			Employer location (city and province)		Group number 4386	Account 01-000
Employee's name			Address of employee Street	Apt/unit #	( ) Area code	Phone numb
Employee I.D.	Sex ☐ M ☐ F	Date of birth Day/Month/Year	City	Province		Postal code
Occupation		Insurance effective date Day/Month/Year	Date employed Day/Month/Year	Last day worked Day/Month/Year	Was more than half day work ☐ Yes ☐ No If no, how many hours?	
Weekly benefit $	Weekly earnings $	Hourly rate $	Date disability caused lost time Day/Month/Year	Date returned to work Day/Month/Year	Tax exempt Basic ____ Other ____	

Please advise if payment has been made (or will be made) to employee for any vacation days or holidays during disability period being claimed for:

☐ Yes ☐ No

If yes, please advise date or dates involved:

From ____________ To ____________

Is illness or injury due to occupational causes? ☐ Yes ☐ No ☐ Unknown

Has a claim been filed with Workers' Compensation Board? If so, provide claim number ____________

Is employee currently working full-time ☐ or part-time on a modified work wee

If modified, from what date ____________ and was it a result

work related absence? ☐ Yes ☐ No

IMPORTANT: Please mark off NORMAL weekly working days

☐ MON. ☐ TUE. ☐ WED. ☐ THURS. ☐ FRI. ☐ SAT. ☐ SUN.

Number of hours worked in a normal work week ________

Date ____________ SIGNATURE OF EMPLOYER'S REPRESENTATIVE ____________

EMPLOYEE COMPLETE

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

Date Signed ____________ Day / Month / Year Signature of Employee ____________

IN CASE OF ACCIDENT:

Date and time Day Month Year ________ ☐ AM ☐ PM	Where did accident occur? (i.e. Home, Business, Other (Specify))
How did accident occur?	What was the claimant doing at time of accident?
Nature of injuries - Specify	

Please send completed claim forms to:

Bricklayers & Stonemasons
Union Local No. 2 (Ontario)
Employee Benefit Trust

Global Benefits
88 St. Regis Crescent South
Toronto, Ontario
M3J 1Y8
Tel: (416) 635-6000

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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

Please return completed form to your patient

SD3 (LOSS OF TIME BENEFIT)
APPROVED BY CMA, AMLFC, CLHIA

Contract number
4386-01-000

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 *(e.g. 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 this patient's care during the full period? ☐ No, comment 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

   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. a) How does present condition affect patient's ability to work *(for example restrictions, limitations, proposed surgery, etc.)*

    b) Is patient fit for trial return to work on part-time or modified basis? ☐ Yes ☐ No If "yes" indicate date

    c) Is patient a suitable candidate for a vocational rehabilitation program? ☐ Yes ☐ No

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 attending physician *(please print)*

Speciality

Telephone number
(   )

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

Signature

Date *(day, month, year)*