

# Group Benefits Member Statement Short Term Group Disability Claim

- To be completed by the employee.
- Please print clearly and answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- **You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement, GL4587E(4096)(6089), and photocopies of file documentation.**

Return completed form to: **Prairie Teamsters Admin. Services**  
**209-7260 12 ST SE, Calgary AB T2H 2S5**  
**Telephone: (403) 252-6924 Fax: (403) 253-3231**  
**or**  
**Manulife Financial Group Benefits, Attention: Disability Claims**  
**PO Box 4217 STN C, Calgary AB T2T 5N1**  
**Telephone: 1-800-561-1400 • (403) 234-9440 Fax: (403) 263-5169**

## 1 Plan member information

Plan contract number	Division number	Social Insurance Number	
Plan employer's name		Job title	
Plan member's full name (last, first, initial)			<input type="radio"/> Mr. <input type="radio"/> Ms. <input type="radio"/> Miss <input type="radio"/> Mrs.
Birthdate (dd/mmm/yyyy)	Preferred language: <input type="radio"/> English <input type="radio"/> French	Height	Weight
Full address (number, street and apartment, P.O. Box number)			
City		Province	Postal code
Telephone number (   )	Fax number (   )	Number of dependants and ages	

## 2 Claim information

Last day worked (dd/mmm/yyyy)

Is your condition due to an accident?    Yes    No   *If no, please go to item 3.*

What kind of accident?  
 Motor vehicle accident    Work related    Other

Name of Motor Vehicle Accident Insurance carrier	Contact Person	Contact's telephone number (   )
Describe how and when injury occurred		Date of accident (dd/mmm/yyyy)
		Time of accident <input type="radio"/> a.m. <input type="radio"/> p.m.

Is there any legal action involved?    Yes    No   *If yes, please provide the following information:*

Lawyer's name	Telephone number (   )
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Was the occurrence investigated by police?    Yes    No  
*If yes, please provide a copy of the police report.*

## 3 Medical information

List all doctors consulted for your present condition.

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition? (dd/mmm/yyyy)
Address of doctor (number and street)	Suite   Date of next visit (dd/mmm/yyyy)
City	Province   Frequency of visits
Postal code	Telephone number (   )   Type of practitioner

**3 Medical information  
(continued)**

List all doctors consulted for your present condition.

Name of Doctor/Specialist		Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number ( )	Type of practitioner	

**4 Work information**

What are your job duties?

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When do you expect to return to your job? Date (dd/mmm/yyyy)

**5 Income/benefit information**

Have you applied for 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.**

**It is important that all sources of income be reported immediately. It is possible that these may impact potential benefit payment.**

INCOME/ BENEFIT	REFERENCE OR CLAIM NO.	BENEFIT DATES (dd/mmm/yyyy)		FREQUENCY				AMOUNT
		START	END	WEEKLY	BI-WEEKLY	MONTHLY	LUMP SUM	
		Any type of workers' compensation board*				<input type="radio"/>	<input type="radio"/>	
Motor Vehicle Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Employment Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Other				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$

\* 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).

**6 Certification, agreement and authorization**

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](http://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)
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