Manulife The Manufacturers Life Insurance Company

Personal Accident Insurance

Initial Claim Form

Please send the completed form to:

For Regular Mail:
Manulife Individual Insurance
Personal Accident Claims Department
PO Box 670, Stn Waterloo
Waterloo, ON N2J 4B8
Tel: 1-888-477-5450
Fax: 416-687-5111
Toll-free Fax: 1-800-363-5123

For Courier:
Manulife Individual Insurance
Personal Accident Claims Department
250 Bloor St. East
Toronto, ON M4W 1E5
Tel: 1-888-477-5450
Fax: 416-687-5111
Toll-Free Fax: 1-800-363-5123

We understand that this can often be an overwhelming time and have prepared this package to assist you in the filing of the claim for Benefits under the policy with Manulife. A checklist is included for your convenience. If any questions arise as you prepare or secure the requested information, please call us from Monday to Friday on our toll-free line at **1-888-477-5450** between 8 a.m. and 5 p.m., EST and ask to speak with a representative from Customer Service.

In order for us to assess a claim, we require the following key pieces of information:

(1) Medical information supporting the cause of your claim, (2) the specific date of claim, and (3) financial information if your monthly benefit amount **exceeds $2,000**.

Please reference your policy before submitting your claim, as your claim will be based on the policy provisions. Depending on your coverage, benefits may only be payable if your claim is a result of an accident, as defined in the policy provisions.

Your policy includes a Pre-Existing Condition Exclusion during the 12 month period immediately following the effective date of coverage. For further details, please refer to the policy Definitions and the Pre-Existing Condition Exclusion.

The enclosed form must be as complete as possible; all required information must be submitted before processing of the claim can commence. Please use the following checklist in order to ensure that all documents noted on the list are provided. Regrettably, incomplete forms or insufficient documentation will compromise our ability to achieve a timely claim decision. We suggest that you maintain a copy of all completed forms for your records.

CHECKLIST FOR SUBMITTING A CLAIM:

- ☐ **Claimant's Statement** – Please provide as much detail as possible, including your response to relevant questions no. 10 – 13, inclusive. We welcome any additional information that you feel may assist us in the evaluation of your claim.
- ☐ **Employer's Statement** – for completion by your present employer, or yourself, if self-employed.
- ☐ **Attending Physician's Statement** – The reverse section of the enclosed form; to be completed by the physician who treated you.
- ☐ **Direct Deposit Consent** – Complete and sign the consent and include a cheque marked ɑvoid" showing your name and current address.
- ☐ A complete copy of your most recent **Personal Income Tax Return**, if your monthly disability benefit is **in excess of $2,000** and a complete **Statement of your Business Activities**, if self-employed.
- ☐ The invoice if you are claiming for **Ambulance Benefit**.

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INITIAL CLAIMANT'S STATEMENT: To be completed by Claimant – New Claim Only

Policy No.(s): _____

1. Name of Claimant: _____ Date of Birth (dd/mmm/yyyy): _____
2. Number & Street: _____ City: _____ Province: _____ Postal Code: _____
3. Telephone No.: ( ) _____ Sex: ☐ M ☐ F Height: _____ Weight: _____

Present Occupation: _____

Please list and describe the important duties of your occupation: _____

4. Dates during which you were totally disabled: From (dd/mmm/yyyy): _____ To (dd/mmm/yyyy): _____
5. Dates during which you were partially disabled: From (dd/mmm/yyyy): _____ To (dd/mmm/yyyy): _____
6. Your family physician's name, address and telephone number: _____
7. List all physicians consulted in the last 2 years. (Attach separate sheet if necessary)

Name	Address	Date (dd/mmm/yyyy)	Reason

8. Have you ever had this or a similar condition? ☐ Yes ☐ No If Yes, give date (dd/mmm/yyyy): _____

Details: _____

9. If you are claiming for hospitalization benefits, **please indicate dates:** From: _____ To: _____

COMPLETE FOR ACCIDENT ONLY

10. Date & time of accident: _____ Location: _____ Injuries sustained/Loss incurred: _____

Describe how accident occurred (attach diagram or extra sheet if necessary): _____

11. If you are claiming for ambulance benefits, **please attach the invoice.**

COMPLETE FOR SICKNESS ONLY

12. Date of first symptoms: _____ Nature of sickness: _____

COMPLETE IF CLAIMING FOR ACCIDENT OR SICKNESS DISABILITY BENEFITS

13.

	Effective date of benefit (dd/mmm/yyyy)	Monthly/Weekly amount (SPECIFY):
☐ Auto insurance disability income		
☐ Other (Specify)		

If you are self-employed, please attach a complete copy of your income tax return filed with Canada Revenue Agency for the year prior to your date of disability.
If you are not self-employed, please attach a copy of your T4 for the year prior to your date of disability.

EMPLOYER'S STATEMENT: To be completed by Employer (If self-employed, to be completed by Claimant)

Name of Employer: _____ Telephone No.: ( ) _____

Employee's title and duties: _____

First day off work due to disability (dd/mmm/yyyy): _____ Is this a Workers' Compensation claim? ☐ Yes ☐ No If yes, provide claim number: _____

Date returned to work part-time (dd/mmm/yyyy): _____ Is this a group disability claim? ☐ Yes ☐ No If yes, provide amount entitled to receive: _____

Date returned to work full-time (dd/mmm/yyyy): _____ Name of group insurer: _____

Employer's Signature/Title: _____ Date (dd/mmm/yyyy): _____

AN INCOMPLETE FORM CAN RESULT IN A DELAY IN THE PROCESSING OF THIS CLAIM

AUTHORIZATION AND CONSENT

Read this section carefully. It explains how your personal information is used.

Your signature on page 2 means that you authorize and consent to the ways we collect, use, share and retain your personal information.

You may not alter any of the wording in this Section. Any attempt to do so will be of no effect. For information on withdrawing your consent, consult the relevant sections below.

Personal information is important

We understand that the privacy of personal information is important to you and we assure you that it's equally important to us. Personal information is fundamental to our business as it allows us to evaluate and administer claims under your policy(ies).

Collecting your personal information

In addition to the personal information you provide in this form, we may collect:

- information from a personal investigation including video surveillance
- employment information from your employer

Using your personal information

We may use the personal information that we collect to:

- confirm your identity and to uniquely identify you
- confirm the accuracy of the information collected
- comply with legal and regulatory requirements
- conduct searches to locate you and update your contact information in our files
- investigate, assess and administer claims with respect to this policy on an ongoing basis.

Sharing personal information

We may share personal information with the following people, service providers or organizations:

- our affiliates and our employees and agents who require this information to perform their jobs
- applicable reinsurers
- the Canada Revenue Agency
- third-party service providers who require this information to provide services to us, which may include:
  - claims investigators and investigative agencies
  - providers of information processing and storage, programming, printing, mailing and distribution services
- your advisor and any agency that employs your advisor or has named your advisor as its agent, either directly or indirectly, and their employees
- the Medical Information Bureau (MIB), as explained in the notice provided in your original disability insurance application if you purchased an underwritten product
- people to whom you have granted access and
- people who are legally authorized to view your personal information.

These people, organizations and service providers may be in other provinces or jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

Protecting and retaining personal information

We protect personal information that we collect and keep it secure by storing it in an individual file. We will keep the personal information we collect for the longer of:

- the time period required by law and by the guidelines set for the financial services industry or
- the time period required to investigate, assess and administer this claim and any future claims under your policy(ies).

Withdrawal of your consent

You may withdraw your consent for us to collect, use, disclose and retain personal information that we need to evaluate and administer the claim on an ongoing basis.

If you withdraw your consent or if your consent is not adequate, you agree that until adequate consent is given the following consequences may apply:

- ***a benefit will not be paid, if you withdraw your consent before the claim is evaluated and processed***
- ***you will not be able to exercise any rights under the policy without our agreement.***

To withdraw your consent for us to collect, use or disclose your personal information, you may contact us at any time by phoning our Customer Service Centre at 1-888-477-5450, or by writing to our Privacy Office at the address below.

Your right to access personal information or to receive additional information

You can ask for a copy of our policies and practices for handling personal information. You can also ask to review your personal information in our files and have any inaccuracies corrected by sending a written request to:

Privacy Officer - Affinity Markets
Manulife, Del Stn 500-4A, PO Box 1602, Waterloo, ON N2J 4C6

You can obtain a copy of our policies and practices for handling personal information by contacting our Privacy Officer or by visiting www.manulife.ca > Privacy Policy.

DIRECT DEPOSIT CONSENT

Once your claim is approved, we will deposit your benefit payments into your bank account using an electronic fund transfer. Your bank account needs to be at a Canadian financial institution.

I authorize Manulife to credit payment for policy number(s)_____ to my account with the financial institution shown on the void cheque provided.
I understand that to stop these instructions, I must give Manulife written notice at least 15 days before the next scheduled payment date.

Name (please print) | Signature | Date (dd/mmm/yyyy)

✘

AUTHORIZATION TO RELEASE INFORMATION

This completed and signed section will be copied and provided to any hospitals or other organization as your authorization to release information to us for this claim.

In this section *cwe*", *cus*" and *cour*" refer to The Manufacturers Life Insurance Company; c*you*" and c*your*" refer to the insured person.

You authorize and direct any doctor, medical practitioner, health care professional, hospital, clinic and other medical or medically related facility, insurance company or their service providers, the Canada Revenue Agency, the Medical Information Bureau, other organization, institution, association or person that has any information, records or knowledge of you, to release to and exchange with us and applicable reinsurers any information about you that we require to administer this claim.

By signing below you are confirming that:

- to the best of your knowledge, all of the information in this claimant's statement is current, correct and complete
- you agree to the terms of this claimant's statement
- you make all authorizations and give your consent as described in this claimant's statement
- you agree that a copy of this authorization shall be as valid as the original.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Name of insured person (please print) | Signature of insured person | Date (dd/mmm/yyyy)

✘

Signature of Legal Representative (attach legal documents) or Beneficiary (in applicable jurisdictions), where Insured is deceased or Signature of Attorney under Power of Attorney (if available) where Insured is incapacitated | Date (dd/mmm/yyyy)

✘

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INITIAL ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name: _____ Date of Birth (dd/mmm/yyyy): _____
2. How long have you been this patient's physician? Since (dd/mmm/yyyy): _____
3. Present condition due to: ☐ An accident ☐ A sickness
4. **Diagnosis (Please print):**
   a) Primary: _____
   b) Secondary (if applicable): _____
   c) Subjective symptoms: _____
   d) Were any tests performed, including current x-rays, ECGs, laboratory data etc.? ☐ Yes (Attach copies of test results) ☐ No
5. Additional conditions which might prolong disability: _____
6. **History:**
   a) When did symptoms first appear or accident happen? (dd/mmm/yyyy): _____ b) Date last worked (dd/mmm/yyyy): _____
   c) Has patient had same or similar condition before? ☐ Yes ☐ No If yes, provide dates (dd/mmm/yyyy): _____
   Describe: _____
7. If patient was hospitalized, name of hospital: _____ From (dd/mmm/yyyy): _____ To (dd/mmm/yyyy): _____ Inclusive
   If in intensive care unit: From (dd/mmm/yyyy): _____ To (dd/mmm/yyyy): _____ Inclusive
8. If surgery was performed, provide date and description of surgery: Date (dd/mmm/yyyy): _____
   Description: _____
9. Date patient first consulted you for present disability (dd/mmm/yyyy): _____ Date of latest visit (dd/mmm/yyyy): _____
   Were you actively supervising this patient's care during the full period of disability? ☐ Yes ☐ No
   If Yes, indicate frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) _____
   If No, please comment: _____
10. Describe the treatment program and frequency: _____
11. Is patient following recommended treatment? ☐ Yes ☐ No If No, please comment: _____
12. Name(s) of any other treating or referring physician(s): _____
13. **Physical Impairment:**
    ☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restrictions
    ☐ Class 2 – Medium manual activity
    ☐ Class 3 – Slight limitation of functional capacity; capable of light work
    ☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
    ☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity
14. List the patient's current restrictions and limitations: _____

At this stage, have return-to-work goals been discussed with the patient? ☐ Yes ☐ No

If 'Yes' please explain the return-to-work plan; if 'No' explain the patient's prognosis and why return-to-work planning is too early or not medically appropriate: _____

15. General Remarks

Note: Your patient is responsible for paying any fee charged for completion of this Attending Physician's Statement (APS).

IMPORTANT: Any reference to testing, tests, test results, or investigations in this section excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

By signing below you confirm that to the best of your knowledge, the information on this APS about your patient is current, correct and complete.

Name of physician (first, middle initial, last) | Telephone number | Fax number

_____ ( ) ( )

Address (street and number) | City or town | Province | Postal code

_____

Certified specialist

☐ No ☐ Yes, specify _____

Signature of physician | Date (dd/mmm/yyyy)

✘ _____

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