

As a Plan Sponsor, complete page 1. You can print pages 2-10 and provide to the plan member or claimant for completion and submission to Manulife.

**Please submit this form to the appropriate address:**

**For English Claims**

Manulife  
PO BOX 400 STN PLACE-D'ARMES  
MONTREAL QC H2Y 3H1  
Tel: 1-877-481-9169  
Fax: 1-866-292-9050  
Email: group\_disability\_claims@manulife.com

**For French Claims**

Manulife  
PO BOX 400 STN PLACE-D'ARMES  
MONTREAL QC H2Y 3H1  
Tel: 1-877-481-9169  
Fax: 1-866-292-9050  
Email: groupe\_invalidite@manuvie.com

**If sending by courier**

Manulife  
ATTN: GROUP LIFE CLAIMS  
2000 MANSFIELD, SUITE 220  
MONTREAL QC H3A 2Y8

**1 Nature of request**

**Please select the benefit type for which the claimant is applying.**

- Death of the member     Death of a dependent     Death of a retiree     Dismemberment

**2 Plan sponsor's statement**

**This section should be completed by the plan sponsor. Declaration must be fully completed.**

Plan contract number \_\_\_\_\_ Division \_\_\_\_\_ Class \_\_\_\_\_ Union local, if unionized \_\_\_\_\_

Plan sponsor name \_\_\_\_\_ Plan sponsor contact name (first, middle initial, last) \_\_\_\_\_

Plan sponsor address (number, street, suite) \_\_\_\_\_ Phone number \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Email address \_\_\_\_\_

Plan member's name (first, middle initial, last) \_\_\_\_\_ Plan member's address (number, street, apt) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Date of birth (dd/mmm/yyyy) \_\_\_\_\_ SIN of plan member \_\_\_\_\_ Permanent employee  Yes  No

Plan member's employment start date (dd/mmm/yyyy) \_\_\_\_\_ Number of hours normally worked per week: \_\_\_\_\_ Plan member's last day worked (dd/mmm/yyyy) \_\_\_\_\_

Certificate number \_\_\_\_\_ Effective date of coverage (dd/mmm/yyyy) \_\_\_\_\_ Termination date of coverage, if applicable (dd/mmm/yyyy) \_\_\_\_\_

Was the plan member absent from work at the time of loss/death?  Yes  No Plan member occupation \_\_\_\_\_

If yes, what is the reason for absence from work:  Sick leave  Layoff  Retired  Leave of absence  Other (please specify): \_\_\_\_\_

Plan member's salary at the last date worked \$ \_\_\_\_\_  Annually  Semi-monthly  Bi-weekly  Monthly  Hourly  Weekly

Effective date of salary (dd/mmm/yyyy) \_\_\_\_\_

Name of deceased (first, middle initial, last) \_\_\_\_\_ Date of loss (dd/mmm/yyyy) \_\_\_\_\_

**Beneficiaries For plan sponsored administered group, provide a copy of the Plan Member Enrolment form or the Beneficiary Designation form.**

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ Date of birth (dd/mmm/yyyy) \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ Date of birth (dd/mmm/yyyy) \_\_\_\_\_

**Please check claimed benefit(s) and specify amounts:**

- Basic Life \$ \_\_\_\_\_  Basic Accidental Death & Dismemberment \$ \_\_\_\_\_  Paid Up Life \$ \_\_\_\_\_
- Optional/Supplemental Life \$ \_\_\_\_\_  Optional/Supplemental Accidental Death & Dismemberment \$ \_\_\_\_\_  Dependent Life \$ \_\_\_\_\_
- Other (please specify) \_\_\_\_\_ \$ \_\_\_\_\_

**Declaration**

**I certify** that the information in this form is true and complete, to the best of my knowledge.

Full name \_\_\_\_\_ Signature \_\_\_\_\_

Title \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

**3 Claimant's statement** If the claimant is a minor beneficiary, the form must be completed on behalf of the minor beneficiary by an appointed trustee or guardian of the child or child's property, in the absence of an appointed trustee.

**Instructions to claimant**

Please indicate one of the situations below, and provide the required document(s).

**Proceeds UNDER \$300,000**

Provide original or copy of Funeral Director's Statement of Death, and newspaper death report or obituary notice (if available)

**OR**

Attending Physician's Report (pages 5 and 6 of this form)

**Proceeds \$300,000 and OVER**

Original or copy of Provincial Death Certificate

**OR**

Attending Physician's Report (pages 5 and 6 of this form)

**Accidental Death**

Attending Physician's or Coroner's Statement (pages 7 and 8 of this form)

**Accidental Dismemberment**

Attending Physician's Statement (pages 9 and 10 of this form)

**Miscellaneous requirements**

**Payments to minor beneficiary**

Original or copy of Court appointment of Guardianship of the Estate of the Minor

**Payments to estate**

Original or copy of the Probated Will or Letters of Administration for proceeds over \$50,000.00

**Beneficiary is deceased**

Copy of deceased Beneficiary's Proof of Death

Please submit this form and the required document(s) to the appropriate address:

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MONTREAL QC H3A 2Y8

Plan contract number \_\_\_\_\_ Plan member certificate number \_\_\_\_\_

Plan member name (first, middle initial, last) \_\_\_\_\_

**Please select the nature of the claim:**

- Death - complete this section with information about the deceased.
- Dismemberment - complete this section about the insured member/dependent who sustained the injury.

Name (first, middle initial, last) \_\_\_\_\_ Marital status  Married  Single

Sex \_\_\_\_\_ Date of birth (dd/mmm/yyyy) \_\_\_\_\_ Date of death/loss (dd/mmm/yyyy) \_\_\_\_\_

Address (number, street, apt) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

If deceased/injured was a dependant child and attending school, name institution \_\_\_\_\_

At time of death/injury, was the dependent employed?  Yes  No If yes, indicate numbers of hours worked per week: \_\_\_\_\_

Please indicate cause of death or, if injury/death caused by an accident, please specify the date and the circumstances:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claimant's name (first, middle initial, last) \_\_\_\_\_

Claimant's relationship to the deceased/injured \_\_\_\_\_ Claimant's date of birth (dd/mmm/yyyy) \_\_\_\_\_

Claimant's address (number, street, apt) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Claimant's primary phone number \_\_\_\_\_ Claimant's SIN \_\_\_\_\_

**3 Claimant's statement (continued)**

To be completed in case of a death claim.

Name of funeral home \_\_\_\_\_ Funeral home phone number \_\_\_\_\_

I claim in the capacity of:  Beneficiary  Executor  Legatee  Heir  Other (please specify) \_\_\_\_\_

**By providing my personal email address, I am authorizing Manulife to use the address provided as an additional means of communication about my file. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.**

Claimant's email address \_\_\_\_\_

Claimant's signature \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

**4 Direct deposit authorization** If the plan sponsor allows direct deposit, and if benefits are approved, please complete this section to consent to receiving benefits by direct deposit.

- If depositing to a chequing account, please sign the authorization, and attach a copy of a void cheque in the area below.
- If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of your banking statement.
- If the deposit is being made to an Estate, please complete the required information, sign the authorization and provide a bank statement/void cheque confirming the Estate account. Otherwise, proceeds will be paid by cheque.

Name of financial institution \_\_\_\_\_

Address of financial institution (number, street, suite) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Type of account:  Chequing  Savings  Estate

Branch or transit number (5 digits) \_\_\_\_\_ Institution number (3 digits) \_\_\_\_\_

Bank account number (maximum 12 digits) \_\_\_\_\_

**I hereby authorize** Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. I agree that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. **I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree** that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, **I authorize** the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. **I authorize** the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Claimant's signature \_\_\_\_\_ Date (dd/mmm/yyyy) \_\_\_\_\_

Claimant's name (please print) \_\_\_\_\_

**If providing a copy of a void cheque, please place it here.**

## 5 Claimant's certification and authorization for all death claims

**I certify** that the information in this form is true and complete, to the best of my knowledge and belief. **I also certify** that any further verbal or written statement provided by me will be true and complete to the best of my ability. **I hereby** claim the group life insurance proceeds payable as a result of the death of the deceased.

Name of deceased/injured (first, middle initial, last) \_\_\_\_\_

### **I understand:**

- that Manulife will investigate this claim and may require information related to the deceased's health, employment, police investigations, autopsy, toxicology or coroners' reports.

### **I authorize:**

- Manulife, its service providers, Manulife's reinsurers and its service providers, and any person or organization who has personal information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution and any other medically-related facility, insurer, police, coroner and investigative agency, to collect, use, maintain and disclose information for the purposes of group plan administration and audits as well as the assessment and investigation of this claim.
- the use of my Social Insurance Number (SIN) for the purpose of tax reporting.

### **I confirm:**

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- that I understand that more specific details regarding how and why Manulife collects, uses, maintains, and discloses personal information can be found in Manulife's Privacy Policy, available at [www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html](http://www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html) or through the Plan Sponsor.

### **I acknowledge:**

- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of any personal information will be limited to Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in the file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Claimant's signature \_\_\_\_\_ Date (dd/mmm/yyyy) \_\_\_\_\_

Claimant's name (please print) \_\_\_\_\_

**Important - Please see instructions on Page 2 (Instructions to claimant) regarding the required document(s) prior to proceeding to pages 5-10.**

## Group Benefits Attending Physician's Report

If there is a charge for the completion of this form, payment is the responsibility of the claimant.  
Please print clearly.

### 1 Plan member identification

Plan member's name (first, middle initial, last) \_\_\_\_\_ Certificate number \_\_\_\_\_  
Plan contract number \_\_\_\_\_ Plan member's date of birth (dd/mmm/yyyy) \_\_\_\_\_

### 2 Physician's report

Deceased's name (first, middle initial, last) \_\_\_\_\_

Place of death \_\_\_\_\_

Date of death (dd/mmm/yyyy) \_\_\_\_\_ Age at death \_\_\_\_\_

If death occurred in an institution or hospital, please give name: \_\_\_\_\_

Residence address at death (number, street, apt.) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

#### Cause of death (Enter only one cause for each of a, b, and c.)

##### Disease and condition directly leading to death:

(This does not mean the mode of dying such as heart failure, asthenia, etc. It means the disease, injury or complication which caused the death).

(a) \_\_\_\_\_

##### Interval between onset and death

(a) \_\_\_\_\_

##### Antecedent causes:

(Morbid conditions, if any, giving rise to the above cause (a) stating underlying causes last).

Due to (b) \_\_\_\_\_

##### Interval between onset and death

(b) \_\_\_\_\_

Due to (c) \_\_\_\_\_

(c) \_\_\_\_\_

To your knowledge, did the deceased ever smoke?  Yes  No  I don't know If yes, how many years? \_\_\_\_\_ year(s)

Date of first attendance in last illness (dd/mmm/yyyy) \_\_\_\_\_

Date of last attendance in last illness (dd/mmm/yyyy) \_\_\_\_\_

If death was due to accident, suicide or homicide, specify which and describe briefly.

Was an inquest held?  Yes  No Was an autopsy performed?  Yes  No

If yes, to either of the above, by whom and what findings?

**Continued on the next page.**

**2 Physician's report (continued)**

Have you treated or advised the deceased during the last five years, prior to last illness?  Yes  No  
Did the deceased, to your knowledge, receive treatment during the last five years from any other physician, or in any hospital or institution?  Yes  No

If yes, to either of the above, please provide the following information.

Name	Address	Nature of illness/injury	Approximate dates (dd/mmm/yyyy)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**3 Attending physician's personal information**

Attending physician's full name \_\_\_\_\_

Specialty \_\_\_\_\_

Address (number, street, suite) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Area code and phone number \_\_\_\_\_

**Attending physician's signature**

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by 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.

Attending physician's signature \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

**Submitting form**

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ATTN: GROUP LIFE CLAIMS  
2000 MANSFIELD, SUITE 220  
MONTREAL QC H3A 2Y8

**Group Benefits****Attending Physician's or Coroner's Statement for Accidental Death**

If there is a charge for the completion of this form, payment is the responsibility of the claimant.

Please print clearly.

**1 Plan member identification**

Plan member's name (first, middle initial, last) \_\_\_\_\_ Certificate number \_\_\_\_\_

Plan contract number \_\_\_\_\_ Plan member's date of birth (dd/mmm/yyyy) \_\_\_\_\_

**2 Attending physician's or coroner's statement for accidental death**

Deceased's name (first, middle initial, last) \_\_\_\_\_

Date of injury (dd/mmm/yyyy) \_\_\_\_\_

Date of death (dd/mmm/yyyy) \_\_\_\_\_

**What was the precise nature and extent of the injury?**

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**What was the primary or immediate cause of death?**

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**Was the deceased ever treated for a similar condition?**  Yes  No

If yes, where and by whom?

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**Were there any contributing or remote causes of death?**  Yes  No

If yes, what were they?

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**Was the injury, described above, by itself and independent of all other causes, sufficient to cause death?**  Yes  No

If no, please explain fully.

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**At the time of the injury, was the deceased under the influence of alcohol or narcotic drugs?**  Yes  No

If yes, please show blood alcohol content and type of drug.

Blood alcohol content \_\_\_\_\_ Type of drug \_\_\_\_\_

**Was an autopsy performed?**  Yes  No**Continued on the next page.**

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### 3 Attending physician's or coroner's personal information

Attending physician's or coroner's full name \_\_\_\_\_

Degree, qualification or specialty \_\_\_\_\_

Address (number, street, suite) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Area code and phone number \_\_\_\_\_

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#### Attending physician's or coroner's signature

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Attending physician's or coroner's signature \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

---

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### 1 Patient authorization (To be completed by patient)

Patient's name (first, middle initial, last) \_\_\_\_\_

Plan contract number \_\_\_\_\_ Plan member certificate number \_\_\_\_\_

I hereby authorize the release to Manulife any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results, my medical history, treatment, and hospital records, for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments. I understand that I am responsible for any fees related to the completion of this form. I understand that Manulife's Privacy Policy and related materials on how and why Manulife collects, uses, maintains and discloses my personal information, is available upon request; on Manulife's website: [www.manulife.ca](http://www.manulife.ca), or through my Plan Sponsor.

Patient's signature \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

### 2 Patient information

Patient's name (first, middle initial, last) \_\_\_\_\_

Patient's mailing address (number, street, apt.) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Did the injury occur at work?  Yes  No

Date of injury (dd/mmm/yyyy) \_\_\_\_\_ Date of first attendance for present injury (dd/mmm/yyyy) \_\_\_\_\_

Please describe the injury.

#### If treated at hospital, please give name, address and details.

Hospital \_\_\_\_\_ Address of hospital (number, street) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

Was the injury described **solely** responsible for the loss?  Yes  No

If *no*, please give details of contributing causes and names and addresses of other physicians consulted.

\_\_\_\_\_

\_\_\_\_\_

### 3 Loss of limb

Please indicate where severance occurred.



RIGHT ARM

Date (dd/mmm/yyyy) \_\_\_\_\_



RIGHT LEG

Date (dd/mmm/yyyy) \_\_\_\_\_



LEFT LEG

Date (dd/mmm/yyyy) \_\_\_\_\_



LEFT ARM

Date (dd/mmm/yyyy) \_\_\_\_\_

Continued on the next page.

#### 4 Loss of sight

Did accident cause total loss of vision?  Yes  No If yes, indicate if:  Both eyes  Right eye only  Left eye only  
In your opinion, can vision be improved?  Yes  No If yes, indicate by:  Treatment  Operation  Lenses

**Please indicate vision in each eye prior to accident:**

Right eye (Snellen scale) \_\_\_\_\_ Left eye (Snellen scale) \_\_\_\_\_

Did accident require the removal of an eye?  Yes  No If yes, indicate if:  Both eyes  Right eye only  Left eye only

Date of removal (dd/mmm/yyyy) \_\_\_\_\_

Please state your recommendations.

**Please indicate present vision in each eye.**

Right eye (Snellen scale) \_\_\_\_\_ Left eye (Snellen scale) \_\_\_\_\_

#### 5 Other losses

Describe the nature and extent of the impairment resulting from the injury.

Is the loss sustained permanent and irrecoverable?

Comments:

#### 6 Physician's authorization

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Attending physician's full name \_\_\_\_\_

Specialty \_\_\_\_\_

Telephone (include area code) \_\_\_\_\_ Fax (include area code) \_\_\_\_\_

Address (number, street, suite) \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Attending Physician's signature \_\_\_\_\_ Date signed (dd/mmm/yyyy) \_\_\_\_\_

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