Manulife Financial

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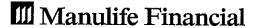
BRICK AND ALLIED CRAFT UNION OF CANADA **BAC - CANADA EMPLOYEE BENEFIT TRUST FUND CONTRACT NUMBER 4221 DISABILITY AND SUPPLEMENTARY HEALTH CARE BENEFITS**

SEND ALL CLAIMS TO: GLOBAL BENEFITS

88 St. Regis Crescent South Toronto, ON M3J 1Y8

CLAIM ENQUIRIES: (416) 635-6000

PLAN MEMBER MUST COMPLETE	E ALL SECTIONS OF THIS F	ORM WHICH ARE PERTIN	IENT TO THE CLAIM
Plan Member's Name:	Init. Last	Identification No	
Pian Member's Address No. and Street			
Plan Member's Date of Birth/	City	Province Is Addr	Postal Code ess New? Yes No
IF CLAIM IS FOR PRESCRIPT DATE OF SERVICE OR PURC	TION OR OTHER COVERED CHASE AND FULL NAME O	SERVICES, ALL RECEIPT F PATIENT AND ATTACH A	S MUST SHOW ALL RECEIPTS.
Claim For: Plan Member Spouse	Children		
If claim is for a dependent child indicate Spouse		<u></u>	
IF CLAIM IS FOR VISION O	Day Month CARE COMPLETE THE FOL	Year OWING AND ATTACH AL	RECEIPTS
Vision care Claim is For		Birth Date	- N-10.
Vision care Claim is For: Plan Member	Patient's Full Name Spouse Childre	n Date of Receipt	Day Month Year
If claim is for a dependent child indicate Spouse		/ Date of Neceipt	Day Month Year
	Day Month	Year	
IF CLAIM IS FOR DISABILITY AND THE REVERSE S	BENEFITS, THE FOLLOWING OF THIS FORM COMPL	NG MUST BE COMPLETE ETED BY ATTENDING PH	D BY MEMBER YSICIAN.
Was the sickness or injury due in any way to the If yes, Give Full Particulars Below.	e patient's employment?	Yes 🗌 No	
First Day of Total Disability/	Year Date Last Worked Toay Month Year	/ / A Day Month Year	A.M P.M
Are you receiving or applying for disability inco	me under The Employment Insurance	Act for any period covered by this	claim?
HAVE YOU ANY OTHER COVER			
I certify that the information in this form is true and complet my providing false, incomplete or misleading information. I me and/or my dependant(s) (where applicable) for the pur adjudication and payment of claims and other relevant purpural www.manulife.ca or by request. I authorize Manulife Financial and/or its authorized represent the course of its investigations, Manulife Financial and/or it or other data concerning me, my medical history and treat insurance that I may have with Manulife Financial, the probeen made, and medical case study or review. I therefore other, any of my Personal Information which they have in medical facility administrator, my employer or former employ department or organization, and investigative or security aguniformation. I understand that any Personal Information the which will be disclosed only to Authorized Individuals. Autengaged by Manulife Financial, in the performance of their that where Manulife Financial and/or its authorized represe such information through my physician. I hereby authorize the use of my Social Insurance Number authorization shall continue so long as the claim for which the representative. A copy of this authorization shall be as valid.	authorize Manulife Financial and/or its author pose of determining eligibility for Manulife Fir poses, all of which are described in more detail is entative to conduct such investigations concers authorized representative will need to gather ment, and my past and present income, emplication of rehabilitation assistance to me, assist authorize Manulife Financial and the followin their possession or control; any physician, heyer and any of their agents performing services ency, market intermediary, credit bureau, person at I provide, or which Manulife Financial and/thorized Individuals include employees of Maduties, as well as persons to whom I have gentative has obtained sensitive medical information for the purpose of administering this claim his authorization has been completed exists,	ized representative to collect, use and discle- ciancial products and services; underwriting in Manulife Financial's Privacy Policy and Pri- ning this claim for disability benefits as it may and exchange certain information about may oyment, education and training (collectively ling me in returning to work, administering to gersons, institutions and organizations to relating to any employee benefits, any fede in returning to any other person, a or its authorized representative has collected intuities Financial and other persons (corpora ranted access in writing, or to any other per tition from someone other than my physician and for tax reporting identification purpose	ose personal information concerning and administration of coverage; the vacy Information Package, available ay require. I understand that, during e, including any information, records called "Personal Information"). This he policy under which my claim has provide to and exchange with each r, hospital, clinic, pharmacy or other rat or provincial government agency, agency or institution having Personal ed, will be kept in a confidential file, ate or individual), firms or agencies son authorized by law. I understand , Manulife Financial will only release as.
DATE: / / PLAN	MEMBER'S SIGNATURE:		
The Manufacturers Life Insurance Company	Page 1 of 2	G	T0014E(4221) (04/2012) •



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Instructions

- Please print.
 Part 1 to be completed by patient.
 Part 2 to be completed by physician.
 Any charge for completing this form is

SD3 (LOSS OF TIME BENEFIT)

	ttending Physician's Statement SD3 (LOSS OF TIME BENEFIT) APPROVED BY CMA, AMLFC, CLHIA	Any charge for completing this form is the patient's responsibility.			
	ease return completed form to your patient art 1: Patient Authorization	Contract Number			
	ime	4221			
. 14		Date of Birth (day, month, year)			
	ereby authorize the release to my Insurer and my policyholder of any information in respect of this claim. tient's Signature	Date (day, month, year)			
 Pa	art 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)				
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 visit during present period of absence from work (day, month, year) b) Date of latest atternal by the property of the period of absence from work (day, month, year)	endance (day, month, year)			
	c) 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)				
To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of preference (day, month, year) To (day, month, year) inclusive		ult of present condition			
	b) If still unable to work, give approximate date patient should be able to return (day, month, year) or	r of weeks before possible return			
10.	Please advise how present condition affects patient's ability to work (for example, restrictions, limitations, propo	sed surgery, etc.)			
11.	Remarks - Please provide comments and further details which you feel would be helpful				
Naı	me of attending physician (please print) Speciality	Telephone No.			
Add	dress (number, street, city, province, postal code) .	()			
Sig	gnature Date (day, r	nonth, year)			