Manulife Financial

For your future™

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 ALL SECTIONS OF THIS FORM WHICH ARE PERTINENT TO THE CLAIM

Plan Member's Name: _____ (First / Init. / Last) **Identification No.** ____/____/____

Plan Member's Address _____ (No. and Street / City / Province / Postal Code)

Plan Member's Date of Birth ____/____/____ (Day / Month / Year) **Telephone** _____ **Is Address New?** ☐ Yes ☐ No

IF CLAIM IS FOR PRESCRIPTION OR OTHER COVERED SERVICES, ALL RECEIPTS MUST SHOW DATE OF SERVICE OR PURCHASE AND FULL NAME OF PATIENT AND ATTACH ALL RECEIPTS.

Claim For: Plan Member _____ Spouse _____ Children _____

If claim is for a dependent child indicate Spouse's date of birth ____/____/____ (Day / Month / Year)

IF CLAIM IS FOR VISION CARE COMPLETE THE FOLLOWING AND ATTACH ALL RECEIPTS.

Vision care Claim is For _____ (Patient's Full Name) **Birth Date** ____/____/____ (Day / Month / Year)

Vision care Claim is For: Plan Member _____ Spouse _____ Children _____ **Date of Receipt** ____/____/____ (Day / Month / Year)

If claim is for a dependent child indicate Spouse's date of birth ____/____/____ (Day / Month / Year)

IF CLAIM IS FOR DISABILITY BENEFITS, THE FOLLOWING MUST BE COMPLETED BY MEMBER AND THE REVERSE SIDE OF THIS FORM COMPLETED BY ATTENDING PHYSICIAN.

Was the sickness or injury due in any way to the patient's employment? ☐ Yes ☐ No
If yes, Give Full Particulars Below.

_____

_____

First Day of Total Disability ____/____/____ (Day / Month / Year) **Date Last Worked** ____/____/____ (Day / Month / Year) **A.M.** _____ **P.M.** _____

If disability is due to accident, date of accident ____/____/____ (Day / Month / Year)

How did the accident happen?

_____

_____

Are you receiving or applying for disability income under The Employment Insurance Act for any period covered by this claim? ☐ Yes ☐ No

HAVE YOU ANY OTHER COVERAGE WHICH WOULD PAY BENEFITS FOR THIS CLAIM? ☐ Yes ☐ No

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 denied or terminated as a result of my providing false, incomplete or misleading information. I authorize Manulife Financial and/or its authorized representative to collect, use and disclose personal information concerning me and/or my dependant(s) (where applicable) for the purpose of determining eligibility for Manulife Financial products and services; underwriting and administration of coverage; the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Manulife Financial's Privacy Policy and Privacy Information Package, available at www.manulife.ca or by request.

I authorize Manulife Financial and/or its authorized representative to conduct such investigations concerning this claim for disability benefits as it may require. I understand that, during the course of its investigations, Manulife Financial and/or its authorized representative will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information"). This insurance that I 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 has been made, and medical case study or review. I therefore authorize Manulife Financial and the following persons, institutions and organizations to provide to and exchange with each other, any of my Personal Information which they have in their possession or control; any physician, health care practitioner, rehabilitation provider, hospital, clinic, pharmacy or other medical facility administrator, my employer or former employer and any of their agents performing services relating to any employee benefits, any federal or provincial government agency, department or organization, and investigative or security agency, market intermediary, credit bureau, personal information agent, or any other person, agency or institution having Personal Information. I understand that any Personal Information that I provide, or which Manulife Financial and/or its authorized representative has collected, will be kept in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife Financial and other persons (corporate or individual), firms or agencies engaged by Manulife Financial, in the performance of their duties, 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 authorized representative has obtained sensitive medical information from someone other than my physician, Manulife Financial will only release such information through my physician.

I hereby authorize the use of my Social Insurance Number for the purpose of administering this claim and for tax reporting identification purposes. 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 are required for Manulife Financial and/or its authorized representative. A copy of this authorization shall be as valid as the original.

DATE: ____/____/____ (Day / Month / Year) PLAN MEMBER'S SIGNATURE: _____

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Attending Physician's Statement

Please return completed form to your patient

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

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.

Contract Number **4221**

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)*

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 attendance *(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)*

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. Please advise how present condition affects patient's ability to work *(for example, restrictions, limitations, proposed surgery, etc.)*

11. Remarks - Please provide comments and further details which you feel would be helpful

Name of attending physician *(please print)*

Speciality

Telephone No.
( )

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

Signature

Date *(day, month, year)*

The patient is responsible for securing this form and for charges made for its completion.