Manulife Financial

Claims Services: *Affinity Markets* 2 Queen Street East, P.O. Box 4213, Stn A, Toronto, ON M5W 5M3
Tel: 1-888-477-5450; Fax: (416) 603-9307; Toll free fax: 1-800-363-5123 *www.manulife.ca*

Personal Accident Insurance Plan

Instructions for submission of a claim for Benefits under your Personal Accident Policy.

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 Financial. 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, (3) financial information if your monthly benefit amount exceeds $2,000., and (4) an Accident Report.

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.

Depending on your effective date of coverage and the date of occurrence, this claim may commence within the Pre-existing Condition exclusion period. A Pre-existing condition is defined as any disease or physical condition, whether diagnosed or not, for which symptoms first occurred, or for which medical treatment was sought, recommended, required or obtained, from or by a physician, or for which drugs were prescribed by a physician, or taken by an Insured Person, during the twelve month period immediately preceding any Coverage Effective Date. Benefits will not be provided if this claim results directly or indirectly, in whole or in part from a Pre-Existing condition during the twelve month period immediately following the effective date of coverage.

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 – 14, 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 attended you.

- [ ] Copy of the **Official Accident or Incident Report or Police Report/collision report** if the claim is related to a motor vehicle accident.

- [ ] The **original invoice** if you are claiming for **Ambulance Benefit.**

- [ ] **Proof of Hospitalization** from the hospital, if you are claiming for **Hospitalization Benefits.**

- [ ] 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 Manufacturers Life Insurance Company

2 Queen St. E., P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3

Initial Claimant's Statement: To be completed by Claimant – New Claim Only

Policy No.(s): ______________________

1. Name of Claimant: ______________________ Date of Birth (D/M/Y): ____________
2. Number & Street: ______________________ City: ____________ Province: ______ Postal Code: ________
3. Telephone No.: (   ) ____________ Sex: ☐ M ☐ F Height: ________ Weight: ________

   Present Occupation:

4. Dates during which you were totally disabled: From (D/M/Y): ____________ To (D/M/Y): ____________
5. Dates during which you were partially disabled: From (D/M/Y): ____________ To (D/M/Y): ____________
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 (D/M/Y)	Reason

8. Have you ever had this or a similar condition? ☐ Yes ☐ No If Yes, give date (D/M/Y): ____________

   Details:

9. If you are claiming for hospitalization benefits, **attach proof of hospitalization**:

   Dates of hospitalization: From (D/M/Y): ____________ To (D/M/Y): ____________

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 your injuries resulted from a motor vehicle accident, and you were the driver of their vehicle, **attach a copy of the police or auto insurance collision report**.
12. If you are claiming for ambulance benefits, **please attach the original invoice**.

Complete for Sickness Only

13. Date of first symptoms:	Nature of sickness:

Complete if Claiming for Accident or Sickness Disability Benefits

14.	Effective date of benefit (D/M/Y)	Monthly/Weekly amount (SPECIFY):
☐ Auto insurance disability income		
☐ Other (Specify)		

If you are self-employed, please attach a copy of your income tax return filed with Revenue Canada 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 (D/M/Y): ____________ Is this a Workers' Compensation claim? ☐ Yes ☐ No

Date returned to work part-time (D/M/Y): ____________ If yes, provide claim number: ____________

Date returned to work full-time (D/M/Y): ____________ Is this a group disability claim? ☐ Yes ☐ No

Name of group insurer: ____________ If yes, provide amount entitled to receive: ____________

Employer's Signature/Title: ______________________ Date: ____________

Authorization and Signature of Claimant

The information requested on this claim form is required to adjudicate your claim. To protect your confidentiality, this information will be maintained in a claim file with Manulife Financial. Access will be restricted to Manulife Financial employees, its reinsurers, agents, third party administrators, or legal representatives and to those whom you have granted access or those authorized by law. Your file is secured in our offices. You may ask to review the personal information in this file and make any corrections in writing. The medical information in this file can only be reviewed by a health care professional. To initiate the review, send a request in writing, with the name and address of the health care professional of your choice to: Information Access Officer, Affinity Markets, Manulife Financial, 2 Queen St. E., P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3.

I certify that the above answers are complete, current and accurate to the best of my knowledge and belief. I understand that it may be necessary for Manulife Financial, its reinsurers, agents, third party administrators or its legal representatives to investigate this claim. I hereby authorize any employers, physicians, health care professional, provincial health insurer, or other persons, hospitals, clinics, institutions, government authorities, insurance companies or any other corporations to release and exchange all records including any medical or benefit payment information, or any other information that may be requested by Manulife Financial, its reinsurers, agents, third party administrators, or legal representatives. I agree that a photocopy of this Authorization shall be as valid as the original.

Claimant's Signature: ______________________ Date: ____________

(IF THE CLAIMANT IS A MINOR, THIS FORM MUST BE SIGNED BY THE PRIMARY INSURED OR OWNER)

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

INITIAL ATTENDING PHYSICIAN'S STATEMENT

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

1. Patient's Name: Date of Birth (D/M/Y):

2. How long have you been this patient's physician? Since (D/M/Y):

3. Present condition due to: ☐ An accident ☐ A sickness

4. **Diagnosis:**
   a) Primary:
   b) Secondary (if applicable):
   c) Subjective symptoms:
   d) Objective and any clinical findings:
   e) 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? (D/M/Y): ____________________
   b) Has patient had same or similar condition before? ☐ Yes ☐ No

   If yes, provide dates (D/M/Y): ____________________

   Describe: ____________________

7. If patient was hospitalized, name of hospital: ____________________

   From (D/M/Y): ____________________ To (D/M/Y): ____________________ (Inclusive)

   If in intensive care unit: From (D/M/Y): ____________________ To (D/M/Y): ____________________ (Inclusive)

8. If surgery was performed, provide date and description of surgery:

   Date (D/M/Y): ____________________ Description: ____________________

9. Date patient first consulted you for present disability (D/M/Y): ____________________

   Date of latest visit (D/M/Y): ____________________

   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. Is patient now totally disabled for: Own Occupation? ☐ Yes ☐ No Any Occupation? ☐ Yes ☐ No

    Dates during which patient was/will be Totally Disabled: From (D/M/Y): ____________________ To (D/M/Y): ____________________

    Dates during which patient was/will be Partially Disabled: From (D/M/Y): ____________________ To (D/M/Y): ____________________

    OR, if indefinite, the estimated number of additional weeks before such return/recovery: ____________ additional weeks.

Remarks: ____________________

____

Physician's Name (Please print): ____________________ Certified Specialist: ☐ Yes ☐ No

Address: ____________________ Telephone No: (   ) ____________________

Signature of M.D.: ____________________ Date: ____________________

AN INCOMPLETE FORM CAN RESULT IN A DELAY IN YOUR PATIENT'S CLAIM

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