Manulife

Colleges, Universities and Institutes Benefits Consortium

Group Benefits
Employee Declaration

Abilities Management Access

- **To be completed by the employee.**
- **Please print clearly and answer all questions.**
- **Additional statements may be submitted if there is insufficient space on this form.**
- **You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement and photocopies of file documentation.**

Return completed forms: **Email:** Vancouver_group_disability_claims@manulife.ca
Fax: 1-866-413-3582
Canada Post: **Manulife Case Management Centre**
1095 West Pender Street
PO BOX 48198, VANCOUVER BC V7X 1N8

1 Employee information

You can obtain your policy number, and your employee certificate number from your employer.

Plan contract number	Employee certificate number	Division
0039941		
Employer's name		Job title
Employee's full name (last, first, initial)		◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.
Date of birth (dd/mmm/yyyy)	Preferred language: ◯ English ◯ French	Height / Weight
Full address (number, street and apartment, PO Box number)		
City	Province	Postal code
Telephone number ( )	Fax number ( )	

2 Case information

Last day worked (dd/mmm/yyyy)

Is the current condition due to an accident? ◯ Yes ◯ No If *no*, please go to item 3.

What kind of accident?

◯ Motor vehicle accident ◯ Work related ◯ Other

Name of Motor Vehicle Accident Insurance carrier	Contact person	Contact's telephone number Ext.
Describe how and when injury occurred		Date of accident (dd/mmm/yyyy)
		Time of accident ◯ am ◯ pm

Is there any legal action involved? ◯ Yes ◯ No If *yes*, please provide the following information:

Lawyer's name	Telephone number

Was the occurrence investigated by police? ◯ Yes ◯ No

If *yes*, please provide a copy of the police report.

3 Medical information

List all doctors consulted for your present condition.

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number, street, suite)		Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits
Postal code	Telephone number Ext. ( )	Type of practitioner

3 Medical information *(continued)*

List all doctors consulted for your present condition.

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number, street, suite)		Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits
Postal code	Telephone number ( ) Ext.	Type of practitioner

Diagnosis

Specific treatment plan (medications, treatments, etc.)

4 Work information

What are your job duties?

When do you expect to return to your job? Date (dd/mmm/yyyy)

5 Certification, agreement and authorization

AMS : Agreement, Authorization & Certification

I acknowledge that my Employer has referred my case to Manulife for the purpose of providing Abilities Management Access, and that Manulife is not responsible for providing benefits in the event of a work absence.

I certify that the information provided by me in the course of Manulife's involvement in my case, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.

I authorize any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, and any medically-related facility, rehabilitation provider, to release my personal information to Manulife and/or its service providers for the purposes of the assessment, and management of my case, including independent medical assessments (the purposes being referred to herein, collectively, as the "Purposes"). **I authorize** Manulife, and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the Purposes.

I authorize Manulife to share and discuss with my Employer any functional limitations and restrictions that may impact my workplace accommodation(s) or my return to productive work.

I authorize the use of my SIN for the purposes of identification, if my SIN is used as my plan member certificate number. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/planmember, or from my Plan Sponsor.

I understand 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 my 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; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Employee's name (please print)	
Employee's signature	Date signed (dd/mmm/yyyy)

PRINT