Manulife

Critical Illness
Claimant's Statement

Mail this completed form to:
Living Benefits Claims
Manulife
250 Bloor Street E
East Tower, 2nd floor
TORONTO ON M4W 1E6

- *You* and *your* refer to the insured person.
- *We*, *us* and *our* refer to the insurer of the policy identified in section 1.
- Answer all questions. Incomplete forms may delay processing of the claim.
- If you have any questions call us at 1-866-575-0684.
- Print clearly.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmissions risks, or monitoring, diagnosis or prognosis.

1 Personal information

Policy number	Name of insured person (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Address (street and number)	Apt.

City or town	Province	Postal code	Home telephone number
			( )

Name of employer

Address (street and number)

City or town	Province	Postal code	Employer telephone number
			( )

Job title	Nature of occupation

Are you self-employed? ◯ Yes ◯ No	Your monthly income prior to illness, after the deduction of business expenses but before the deduction of income taxes $

2 Claim information

1. Describe fully the nature and extent of the condition.

2. When did symptoms first commence?
   Describe the symptoms.

   Date (dd/mmm/yyyy – for example, 27/APR/2007)

3. When was a physician first consulted in connection with the condition?

   Date (dd/mmm/yyyy)

Name of physician consulted	Telephone number
	( )

Physician's address

4. Was this the insured person's usual physician? ◯ Yes ◯ No
5. Were any tests or investigations performed? ◯ Yes ◯ No
   If *yes*, tell us details and dates.

6. When was the condition diagnosed?

   Date (dd/mmm/yyyy)

7. If surgery was required, when was it performed?

   Date (dd/mmm/yyyy)

2 Claim information *(continued)*

8. Has the insured person previously suffered from or received treatment for a similar or related condition?

   If *yes*, tell us full details and dates.

9. If this claim results from an accident, describe the incident and provide a copy of the police report.

3 Medical consultations information

1. Physician or clinic you use regularly:

Name	Address

2. Doctors or specialists consulted about the condition:

Name	Address	Date of consultation (dd/mmm/yyyy)

3. If there was any treatment at a hospital or similar institution, tell us:

Name of hospital	City or town	Date of admission (dd/mmm/yyyy)	Date of discharge (dd/mmm/yyyy)

4. What other treatment was received and is currently being received for the condition? (e.g. medications, therapy, etc.)

Type of treatment	Institution / Prescribing physician	Date (dd/mmm/yyyy)

4 General information

1. Has the father or mother or any of the brothers or sisters of the insured person ever suffered from a similar or related condition? If *yes*, tell us:

Relationship	Name of condition	Date condition first diagnosed (dd/mmm/yyyy)

2. Is the insured person insured for benefits related to this condition with another company? If *yes*, tell us:

Name of insurer	Policy number	Type of benefit	Amount of benefit insured	Has claim been submitted?	Issue date (dd/mmm/yyyy)
			$	◯ Yes ◯ No	
			$	◯ Yes ◯ No	
			$	◯ Yes ◯ No	

4 General information *(continued)*

3. Does the insured person use any form of tobacco, marijuana, nicotine products or nicotine substitutes? ◯ Yes ◯ No

   If *yes*, tell us the amount used per day. _____

   How long have these been used? _____

   If *no*, did the insured person previously use any of these? ◯ Yes ◯ No

   When did the insured quit? Date (dd/mmm/yyyy – for example, 27/APR/2007)

4. Tell us any other information that might support this claim.

5 Authorization, agreements and signatures

Read this section carefully. It explains how your personal information is used.

Your signature on page 4 means that you authorize and consent to the ways we collect, use, share and retain your personal information.

You may not alter any of the wording in section 5. Any attempt to do so will be of no effect. For information on withdrawing your consent, consult the relevant sections on the next page.

Personal information is important

We understand that the privacy of personal information is important to you and we assure you that it's equally important to us. Personal information is fundamental to our business as it allows us to evaluate and administer claims under your policy.

Collecting your personal information

In addition to the personal information you provide in this form, we may collect:

- information from a personal investigation including video surveillance, credit bureau and/or consumer report
- employment information from your employer
- income and revenue information from the Canada Revenue Agency
- business information from your customers

Dealing with us by telephone

Customer service calls are recorded for service quality control, information verification and training.

Using your personal information

We may use the personal information that we collect to:

- confirm your identity and to uniquely identify you
- confirm the accuracy of the information collected
- comply with legal and regulatory requirements
- conduct searches to locate you and update your contact information in our files
- investigate, assess and administer claims with respect to this policy on an ongoing basis.

In addition, we may use your social insurance number and your business number (if applicable) to uniquely identify you, confirm your income information with the Canada Revenue Agency, if required and to fulfill our tax-reporting requirements.

Sharing personal information

We may share personal information with the following people, service providers or organizations:

- our affiliates and our employees and agents who require this information to perform their jobs
- applicable reinsurers
- the Canada Revenue Agency
- third-party service providers who require this information to provide services to us, which may include:
  - claims investigators and investigative agencies
  - providers of information processing and storage, programming, printing, mailing and distribution services
- your advisor and any agency that employs your advisor or has named your advisor as its agent, either directly or indirectly, and their employees
- the Medical Information Bureau (MIB)
- people to whom you have granted access and
- people who are legally authorized to view your personal information.

These people, organizations and service providers may be in other provinces or jurisdictions outside Canada. Your information may be shared as required by the laws of those jurisdictions.

Protecting and retaining personal information

We protect personal information that we collect and keep it secure by storing it in an individual file. We will keep the personal information we collect for the longer of:

- the time period required by law and by the guidelines set for the financial services industry or
- the time period required to investigate, assess and administer this claim and any future claims under your policy.

continued...

5 Authorization, agreements and signatures *(continued)*

You can obtain a copy of our policies and practices for handling personal information by contacting our Privacy Office or by visiting www.manulife.ca > Privacy Policy.

Withdrawal of your consent

You may withdraw your consent for us to collect, use, disclose and retain personal information that we need to evaluate and administer the claim on an ongoing basis.

If you withdraw your consent or if your consent is not adequate, you agree that until adequate consent is given the following consequences may apply:

- a benefit will not be paid, if you withdraw your consent before the claim is evaluated and processed
- you will not be able to exercise any rights under the policy without our agreement.

To withdraw your consent for us to collect, use or disclose your personal information, you may contact us at any time by phoning our Customer Service Centre at 1-866-575-0684, or by writing to our Privacy Office at the address below.

Your right to access your personal information

You can also ask to review your personal information in our files and have any inaccuracies corrected by sending a written request to:

Privacy Office - Individual Insurance
25 Water Street S.
PO Box 800, Stn C,
Kitchener ON N2G 4Y5

How we resolve complaints

To discuss any questions or concerns you may have, please contact your advisor or our head office at:

1-888-626-8543 outside Quebec **or** 1-888-626-8843 in Quebec

More information about our complaint resolution process is available on the Internet at www.manulife.ca under *Contact Us* > *Complaint resolution*.

Signatures

Review this form, including the authorizations and agreements on pages 3 and 4 and sign below. By signing below confirm that:

- you have read this form and confirm that the statements in it are complete, current and accurate.
- you agree to the terms of this claimant's statement.
- you make all authorizations and give your consent as described in this claimant's statement.
- you agree that a copy of this document is as valid as the original.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Name of insured person (print)	
Signature of insured person ✘	Date (dd/mmm/yyyy)
Signature of beneficiary (in applicable jurisdictions) or legal representative if insured person is a minor or is incompetent (attach applicable documents) ✘	Date (dd/mmm/yyyy)

6 Authorization to share information

This completed and signed section will be copied and provided to any hospitals or other organization as your authorization to release information to us for this claim.

You and *your* refer to the insured person. *Us* and *our* refer to The Manufacturers Life Insurance Company (Manulife). By signing below, you authorize and direct doctors and other medical practitioners, health care professionals, hospitals, clinics and other medically related facilities, insurance companies, the Medical Information Bureau and any other organization, institution, association or person that has information, records or knowledge of you or your health, to share or exchange information with us or applicable reinsurers.

IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmissions risks, or monitoring, diagnosis, or prognosis.

Signed at (city or town)		Date (dd/mmm/yyyy)
Signature of insured person ✘	Signature of witness ✘	

Check form for errors