Manulife

The Manufacturers Life Insurance Company

Personal Accident Insurance

Initial Claim Form

Please send the completed form to:

For Regular Mail:
Manulife Affinity Markets
Personal Accident Claims Department
P.O. Box 4213, Stn A
Toronto, ON M5W 5M3
Tel: 1-888-477-5450
Fax: 416-687-5111
Toll-free Fax: 1-800-363-5123

For Courier:
Manulife Affinity Markets
Personal Accident Claims Department
250 Bloor St. East
Toronto, ON M4W 1E5
Tel: 1-888-477-5450
Fax: 416-687-5111
Toll-Free Fax: 1-800-363-5123

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. 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** – 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.
- ☐ **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 **original invoice** if you are claiming for **Ambulance Benefit**.

The Manufacturers Life Insurance Company

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 (M/D/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 the 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 If yes, provide claim number: _____

Date returned to work part-time (D/M/Y): _____ Is this a group disability claim? ☐ Yes ☐ No If yes, provide amount entitled to receive: _____

Date returned to work full-time (D/M/Y): _____ Name of group insurer: _____

Employer's Signature/Title: _____ Date: _____

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

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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. Access will be restricted to Manulife 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: Privacy Officer, Manulife, Del. Stn 500-4-A, P.O. Box 1602, Waterloo, ON, N2J 4C6.

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, 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, its reinsurers, agents, third party administrators, or legal representatives. I agree that a photocopy of this Authorization shall be 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.

Fraud Notice: Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties. In addition the insurer may deny insurance benefits if false information materially related to a claim or an application for insurance was provided by the applicant.

Claimant's Signature: _____ Date: _____

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

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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.: ( ) _____ Fax No.: ( ) _____

Signature of M.D.: _____ Date: _____

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