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 form and photocopies of file documentation.**

**Please return the completed form by fax to: 1-866-413-3582**

If you do not have access to a fax, mail the form to:

Manulife Case Management Centre
PO BOX 400
STN PLACE-D'ARMES,
MONTREAL QC H2Y 3H1
**Phone:** 1-800-575-2200
**Email:** Vancouver_group_disability_claims@manulife.ca

## 1 Employee information

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

*Select male, female or non-binary (intersex) consistent with your current biological sex.

For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

| Plan contract number | Employee certificate number | Employer's name |
|---|---|---|
| | | |

| Employee's full name (last, first, initial) | Job title |
|---|---|
| | |

| Date of birth (dd/mmm/yyyy) | Preferred language | Height | Weight | Sex* |
|---|---|---|---|---|
| | ◯ English ◯ French | | | ◯ Male ◯ Female ◯ Non-binary |

| Full address (number, street and apartment, PO BOX number) |
|---|
| |

| City | Province | Postal code |
|---|---|---|
| | | |

| Telephone number | Fax number | Number of dependants |
|---|---|---|
| ( ) | ( ) | |

By providing my personal email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

| Email address |
|---|
| |

## 2 Case information

| Last day worked (dd/mmm/yyyy) | Is your condition due to an accident? ◯ Yes ◯ No<br>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 |
|---|---|---|
| | | |

| 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 and suite)

Date of next visit (dd/mmm/yyyy)

City | Province | Frequency of visits

Postal code | Telephone number ( ) Ext. | Type of practitioner

**Name of Doctor/Specialist**

Approximately when did you first seek medical attention for this condition? (dd/mmm/yyyy)

Address of doctor (number, street and 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? (dd/mmm/yyyy)

## 5 Certification, agreement and authorization

**I confirm:**

- that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- that a photocopy or electronic version of this authorization shall be as valid as the original.
- 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 relation to my current employment absence.

**I authorize:**

- Manulife and/or its service providers, its reinsurers and its service providers, and any person or organization who has personal information about me, including an administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claim(s), including independent medical assessments.
- Manulife to share and discuss with my employer information regarding my functional limitations, restrictions and obstacles to return to work for the purposes of confirming the anticipated duration of my functional limitations and/or my workplace absence to assist in my return to productive work and I acknowledge that my medical information will not be provided to my employer unless my consent is explicitly obtained.

**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, available at https://www.manulife.ca/corporate/privacy-policy.html or from my plan sponsor.
- 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 or disclosure of 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 or authorized disclosure; 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.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Employee's signature | Date signed (dd/mmm/yyyy)