Manulife

Group Benefits
Employee Statement
Short-Term Disability Advisory Services

- Please ensure to answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- Please note for short-term disability there are limitations and exclusions within your contract plan.
- Please refer to your Benefit Booklet to help you understand your coverage, paying particular attention to periods for which you are not entitled to benefits and the exclusions sections.
- To ensure prompt handling, please ensure that you provide your signature in section 6.

Return completed form to: **Manulife**
Group Benefits
Attention: Disability Claims
PO BOX 800 STN C
KITCHENER ON N2G 4Y5

Tel: 1-877-481-9169 • (519) 747-7000
Fax: (519) 579-3680
Email: group_disability_claims@manulife.com

1 Employee information

Plan contract number: 127654

Employer name: Labatt Brewing Company Limited

Enter below your first and last name as it appears on your identification documents, such as health card, driver's licence or passport.

Employee last name | Employee first name | ◯ Male ◯ Female

Home address (number, street, apt.) | Date of birth (dd/mmm/yyyy)

City | Province | Postal code

Preferred language: ◯ English ◯ French | Home telephone number ( ) | Mobile/other phone number ( )

Job title | Employee identification number | Division number

Height | Weight

Date of hire (dd/mmm/yyyy) | Date last worked (dd/mmm/yyyy) | First day of absence (dd/mmm/yyyy)

Personal email address | Number of dependants and ages

2 Advanced disability notification

Complete this section only if you are not currently disabled but will likely become in the near future. (e.g. planned surgery, invasive treatment, etc.)

Is your absence due to a planned intervention such as surgery, treatment, etc.? ◯ Yes ◯ No

Expected last day at work (dd/mmm/yyyy) | Date of procedure, if applicable (dd/mmm/yyyy)

If possible, provide details of the intervention such as date, type, name of facility and/or physician that will perform the intervention.

Please provide details for the reasons for the expected work absence.

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.

Employer name	Employee last name	Employee first name	Employee identification number
Labatt Brewing Company Limited			

3 Accident/injury information

Is your condition due to an accident? ◯ Yes ◯ No If *no*, please go to **section 4**.

What kind of accident? ◯ Motor vehicle accident ◯ Work-related ◯ Other _____

Name of insurance carrier	Claim number

Name of contact person at insurance company or workers' compensation board	Contact telephone number Ext.
	( )

Describe how and when injury occurred.	Date of accident (dd/mmm/yyyy)
	Time of accident ◯ am ◯ pm

Was the occurrence investigated by police? ◯ Yes ◯ No

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

Is there any legal action involved? ◯ Yes ◯ No

If *yes*, please provide the following information:

Lawyer's name	Telephone number Ext.
	( )

4 Medical information

List all doctors consulted for your present condition.

Name of doctor/specialist	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	Postal code
Telephone number Ext. ( )	Fax number ( )	Type of practitioner/specialty

Name of doctor/specialist	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	Postal code
Telephone number Ext. ( )	Fax number ( )	Type of practitioner/specialty

5 Work information

What are your job duties?

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

During this period of disability, did you work at any other occupation? ◯ Yes ◯ No ◯ Do not know

If *yes*, please provide details.

Are you aware of any work or non-medical factors that may impact your successful return to work? ◯ Yes ◯ No ◯ Do not know

If *yes*, please provide relevant details.

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Employer name	Employee last name	Employee first name	Employee identification number
Labatt Brewing Company Limited			

6 Certification, agreement and authorization

I acknowledge that my Employer has referred my case to Manulife for the purpose of providing Short Term Disability Adjudication Services, and that Manulife is not responsible for providing benefits in relation to my current employment 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, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit program, the Medical Information Bureau and investigative agency, to release my personal information to Manulife and/or its service providers for the purpose of plan administration, audit, and the assessment, investigation and management of my case, including, but not limited to, independent medical assessments (collectively, the "Purposes"). **I authorize** Manulife, its reinsurers 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 information regarding my functional limitations, restrictions and obstacles to return to work for the purpose of confirming the anticipated duration of my functional limitations and/or my workplace absence, and assisting in my return to productive work. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original. **I authorize** the use of my Social Insurance Number ("SIN") for the purpose of identification and administration, if my SIN is used as a certificate number for my employer's plan.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a group life, health, and/or disability case file. Access to my 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.

By providing my personal email address, **I am authorizing** Manulife to use the email address provided as an additional means of communication with me about my case. **I acknowledge** that correspondence by email may contain personal information including, but not limited to medical, employments and financial information.

I understand that my personal information is being sent in manner that is not yet guaranteed as a secured means of communication.

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 Employer.

Employee signature	Date signed (dd/mmm/yyyy)

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.