Manulife

Nova Scotia Public Service
Long Term Disability Plan Trust Fund

# Group Benefits Plan Member Statement
# Group Disability Claim Form

Manulife is committed to keeping information confidential. Disability benefits under this plan are self-insured by the Nova Scotia Public Service LTD Plan Trust Fund, ("the LTD Fund"), which means it funds the claims. Manulife provides disability administration services such as initial claims assessment and ongoing case management based on the terms of the Nova Scotia Public Service Long Term Disability Plan, ('the LTD Plan").

- **Please ensure to answer all questions.**
- **Additional statements may be submitted if there is insufficient space on this form.**

**Please send completed form to:**

**Manulife Group Benefits**
Attention: Disability Claims
PO BOX 1030 STN CENTRAL, HALIFAX NS B3J 2X5
Tel: 1-800-565-0627
Fax: 1-866-292-9050
Email: group_disability_claims@manulife.ca

## 1 Benefit application

**Please select the benefit type for which the plan member is applying.**

☑ Long term disability

## 2 Plan member information

Department/Employer name _____

Plan contract number **84560**

Full name (first, middle initial, last) _____

SIN _____ Date of birth (dd/mmm/yyyy) _____

Sex* ◯ Male ◯ Female ◯ Non-binary

**Select male, female or non-binary 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.*

Height _____ Weight _____ Number of dependents and ages _____ Language preference: ◯ English ◯ French

Street address (number, street, apt) _____

City _____ Province _____ Postal code _____

Primary phone number ( ) _____ Alternate phone number ( ) _____

Work phone number ( ) _____ Ext. _____

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 _____

## 3 Direct deposit authorization

**Please complete this section to receive benefits by direct deposit in the event that your claim is approved.**

◯ **If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement**

◯ **If depositing into a chequing account, please sign the authorization, and attach a copy of a void cheque**

Name of financial institution _____

Address of financial institution (number, street, suite) _____

City _____ Province _____ Postal code _____

Type of account: ◯ Chequing ◯ Savings

Branch or transit number (5 digits) _____ Institution number (3 digits) _____

Bank account number (maximum 12 digits) _____

**I hereby authorize** Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. **I agree** that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. **I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree** that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan member signature _____ Date (dd/mmm/yyyy) _____

Plan member name (please print) _____

**If providing a copy of a void cheque, please place it here.**

## 4 Injury information

Occupation _____ Original date of hire (dd/mmm/yyyy) _____

Is your injury/illness work related? ◯ Yes ◯ No

If *no*, was the reason you stopped working due to: ◯ Illness ◯ Injury away from work ◯ Motor vehicle accident
(Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

Is there any legal action? ◯ Yes ◯ No If *yes*, please provide the lawyer's contact information.

Lawyer's name _____ Phone number ( ) _____ Ext. _____

Lawyer's address (number, street, suite) _____

City _____ Province _____ Postal code _____

## 5 Work information

What was the last date at work? (dd/mmm/yyyy) _____

Was this a full day/shift? ◯ Yes ◯ No If *no*, how many hours were worked on your last day? _____

Have you performed any other paid or volunteer work since that date? ◯ Yes ◯ No

If *yes*, please describe. Dates (dd/mmm/yyyy)

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

## 6 Illness information

When were you first treated by a physician for the current absence? (dd/mmm/yyyy) _____

Please describe your symptoms and their frequency.

What work duties do your symptoms prevent you from performing?

Have you ever had the same or similar illness or injury? ◯ Yes ◯ No

Did it result in an absence from work? ◯ Yes ◯ No If *yes*, please describe, include dates and treatment provided.

Do you have an expected return to work date? ◯ Yes ◯ No If *yes*, please provide the date (dd/mmm/yyyy) _____

## 7 Health care professional information

**Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.**

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number ( ) _____ Fax number ( ) _____

**Consulted:** From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

## 7 Health care professional information (continued)

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number ( ) _____ Fax number ( ) _____

**Consulted:** From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number ( ) _____ Fax number ( ) _____

**Consulted:** From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

## 8 Other income information

**If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.**

| Source | Have you applied? Yes | Have you applied? No | Are you receiving payment? Yes | Are you receiving payment? No | Date benefit commenced? (dd/mmm/yyyy) | Amount ($) | Please describe or provide claim number, contact name and telephone number |
|---|---|---|---|---|---|---|---|
| Canada/Quebec Pension Plan | | | | | | | |
| ◯ Disability<br>◯ Retirement | ◯ | ◯ | ◯ | ◯ | | | |
| Worker's compensation* | ◯ | ◯ | ◯ | ◯ | | | |
| Employment insurance | ◯ | ◯ | ◯ | ◯ | | | |
| Auto insurance | ◯ | ◯ | ◯ | ◯ | | | |
| Other insurance | ◯ | ◯ | ◯ | ◯ | | | |
| Income from any other source | ◯ | ◯ | ◯ | ◯ | | | |

* Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

## 9 When to contact Manulife

**NOTIFY MANULIFE PROMPTLY IN THE FOLLOWING CASES**

**I acknowledge** I must notify Manulife immediately if:

a) my medical condition improves, even though I have not yet returned to work
b) I start work either as an employee or a self-employed person
c) I apply for benefits under any workers' compensation law or plan as defined in section 8
d) I apply for benefits under Canada/Quebec Pension Plan
e) I receive any benefits or income from any other source
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disability
h) I am leaving the country or traveling
i) I am or will be returning to school

Plan member signature _____ Date (dd/mmm/yyyy) _____

## 10 Agreement, authorization and acknowledgement

Please sign this authorization and send to Manulife using one of the following methods.

| | |
|---|---|
| Via fax: | 1-866-292-9050 |
| Via email: | group_disability_claims@manulife.ca |
| Via regular mail to: | **Manulife Group Benefits**<br>Attention: Disability Claims, PO BOX 1030 STN CENTRAL, HALIFAX NS B3J 2X5 |

**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 my claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- I am required to refund any monies that I may owe to Manulife in accordance with the provisions of the LTD Plan administered by Manulife, and I authorize Manulife to deduct monies from my LTD Benefit.
- that a photocopy or electronic version of this authorization shall be as valid as the original.

**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 use my SIN for the purposes of tax reporting and identification and administration, if my SIN is used as my plan member certificate number.
- Manulife to release information to my Employer/LTD Fund or a Third Party Administrator of the LTD Fund for plan administration purposes.

**I acknowledge:**

- that my medical information will not be provided to anyone other than the Office of the LTD Fund, unless my consent is explicitly obtained.
- 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 the Office of the LTD Fund.
- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group 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 and I understand that this may impact the administration of my claim and any benefit payment.
- I understand and agree that Manulife is administering this claim on behalf of the LTD Fund and that any records that Manulife possesses in relation to my claim are the property of the LTD Fund. I irrevocably authorize Manulife to only release this information or these records to the Office of the LTD Fund, for any purpose connected with the functions of the said Office.
- the Long Term Disability benefit is being provided directly by the LTD Fund, which has contracted with the Manufacturer's Life Insurance Company (Manulife) to adjudicate and administer the claims for this benefit. By signing this document I acknowledge that while Manulife may issue benefit payments, this benefit is the liability of the LTD Fund.

Plan member signature _____ Date (dd/mmm/yyyy) _____

Plan member name (please print) _____

**Please note:** The information in this statement will be kept in a group 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.

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