

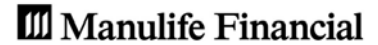


# Application for Continued Benefits

Long Term Disability (LTD)

## Claimant Statement

Group Policy # \_\_\_\_\_



LTD Claim No. \_\_\_\_\_

### 1. MEMBER INFORMATION

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Service Number (SN)	Surname	First Name	Initials
<input type="text"/>		<input type="text"/>	<input type="text"/>
Mailing Address		Home Phone #	
<input type="text"/>		<input type="text"/>	
PO Box, Rural Route, etc.		(circle) work/cell phone/pager #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	Prov.	Postal Code	Email address

### 2. CLAIMANT STATEMENT DETAILS

A. Please list any current, active medical condition(s):

\_\_\_\_\_

\_\_\_\_\_

B. Describe fully the condition(s) you have listed above, including any physical/psychological limitations imposed on you by (each of) the above condition(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. Describe what activities/work you are capable of performing either indoors or outdoors:

\_\_\_\_\_

\_\_\_\_\_

D. Has there been any improvement in your medical condition(s) since your release from the Canadian Forces? Describe:

\_\_\_\_\_

\_\_\_\_\_

E. Do(es) your medical condition(s) prevent you from engaging in suitable, gainful employment for wage or profit, or from participating in courses/training?

Yes  No If "Yes", please explain:

\_\_\_\_\_

\_\_\_\_\_

F. i) What courses/training have you completed?

\_\_\_\_\_

ii) In what courses/training are you currently involved?

\_\_\_\_\_

G. Are you currently working?  Yes  No If "Yes",  Part-time \_\_\_\_ hrs/wk  Full-time

Date commenced employment: \_\_\_\_\_ Gross monthly salary: \_\_\_\_\_

Day Month Year

Name and address of employer: \_\_\_\_\_

Service Number (SN):

**2. CLAIMANT STATEMENT DETAILS (CONTINUED) . . .**

H. i) If you are not presently employed, what are your current/future plans for employment or retraining?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ii) What date do you anticipate returning to work? \_\_\_\_\_  
 Day Month Year

I. If you are not employed, have you discussed returning to work with your doctor?  Yes  No

If "Yes" what did he/she advise as to when you could return to work?

\_\_\_\_\_

\_\_\_\_\_

J. Are you receiving disability benefits from any of the following sources? If "Yes", indicate monthly amount.

	Yes	Current Amount	No	If "No", have you made application for this benefit?	
i) Canada Pension Plan (CPP) (claimant portion only)	<input type="checkbox"/>	_____	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ii) Veterans Affairs Canada (VAC) (including dependants)	<input type="checkbox"/>	_____	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
iii) Other sources	<input type="checkbox"/>	_____	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Provide details for Item (iii) above: \_\_\_\_\_

**3. ATTENDING PHYSICIAN/SPECIALISTS**

Current Attending Physician's name: (Please print)	Specialty
Address of Attending Physician	Telephone No. of Attending Physician
Current Specialist's name, if applicable: (Please print)	Specialty
Address of Specialist	Telephone No. of Specialist

**4. GENERAL INFORMATION**

Marital Status: Single  Married  Divorced  Separated  Other

Number of Dependant Children: \_\_\_\_\_ Age(s):

Member's Date of Birth: \_\_\_\_\_  
 Day Month Year

**5. SIGNATURE**

**Declaration and Authorization by Applicant**

- a. I certify that all information given on this form is complete and true in every respect and is given for the purpose of securing Continued Benefits set forth by the Long Term Disability (LTD) Provision contained in the insurance agreement;
- b. I authorize SISIP Financial Services, Manulife Financial or its reinsurers, for underwriting, administration of insurance and claims paying purposes, to gather only the necessary information for the object of the file, from any person or organization that has personal information relating to me; and
- c. I also authorize SISIP Financial Services, Manulife Financial or its reinsurers, to disclose only the necessary personal information they have on me to the same persons or organizations specified in paragraph b.

The information provided on this form is protected from unauthorized disclosure under Canada's *Privacy Act* and is available to you upon request.

Member's Signature \_\_\_\_\_ Day Month Year

Please return completed form to: Manulife Financial, SISIP Services, 2727 Joseph Howe Drive, PO Box 1030, Halifax, NS B3J 2X5