FINANCIÈRE SISIP FINANCIAL

A division of CFMWS
Une division des SBMFC

Manulife

Department of National Defence

Claim for Accidental Dismemberment Insurance Plan (ADIP) Benefit

Manulife Financial
Policy Number 906906

A CLAIM CONSISTS OF SISIP FS INS 12E (PART I) PAGES 1 & 2 AND SISIP FS INS 13E (PART II) PAGES 1 & 2

Instructions to Canadian Forces Personnel

The ADIP provides a lump-sum benefit for an accidental dismemberment or the loss of sight, speech or hearing, which is attributable to military service and occurred by way of accidental, external and violent means.

Please complete and sign SISIP FS INS 12E (Part I— pages 1&2) and then have your attending physician complete SISIP FS INS 13E (Part II— pages 1&2).

Please note that you are responsible for any costs associated with the completion of the forms. Answer all questions fully. If there is insufficient space for your answers, use separate sheets (indicate your name and Service Number) and attach them to the form.

Once the forms have been completed in their entirety, if available, please attach a copy of the completed form CF98 (Report on Injuries), which should be sent directly to Manulife Financial at the address below.

Manulife Financial
SISIP Claims Department
PO Box 1030
2727 Joseph Howe Drive
Halifax, NS B3J 2X5

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Part I — TO BE COMPLETED BY CF PERSONNEL

1. MEMBER INFORMATION

Service Number (SN) | Rank | Surname | First Name | Initials

Mailing Address

PO Box, Rural Route, etc.

City | Prov. | Postal Code

Home Phone # ( ) | (circle) work/cell phone/pager # ( )

CHECK ONE ONLY:

- ☐ Regular Force
- ☐ Released
- ☐ P Res Class A
- ☐ P Res Class B
- ☐ Reserve Class C

2. CLAIM DETAILS

A. According to the Schedule of Benefits (see Annex A attached), please indicate the Dismemberment/Loss of Use for which you are claiming:

B. Date accident occurred: Day Month Year

C. Date injury first treated by physician: Day Month Year

D. Where accident occurred:

E. Give a brief description of the accident :

F. Explain why you consider that your dismemberment/loss of use is attributable to Military Service (please refer to CFAO 24-6 paragraph 30):

G. Name and mailing address of your Attending Physician:

Part I— TO BE COMPLETED BY CF PERSONNEL (Continued) . . .

Service No:

3. Declaration and Authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that both my claim and my coverage may be denied as a result of my providing false, incomplete or misleading information.

I authorize Manulife Financial and/or SISIP Financial Services to conduct such investigations concerning this claim for accidental dismemberment benefits as they may require.

I understand that, during the course of their investigations, Manulife Financial and/or SISIP Financial Services will need to gather and exchange certain information about me, including any information, records or other data concerning me, my medical history and treatment, and my past and present income, employment, education and training (collectively called "Personal Information").

My Personal Information may be used for the following purposes, where Manulife Financial and/or SISIP Financial Services deem it necessary for:

- the evaluation of this or any other claim for benefits or applications for insurance that I may have with SISIP Financial Services;
- administering the policy under which my claim has been made;
- medical case study or review.

I therefore authorize Manulife Financial, SISIP Financial Services and the following persons, institutions and organizations, to provide to and exchange with each other, any of my Personal Information which they have in their possession or control:

- any physician, health care practitioner, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment:
- any provincial health insurance plan, insurance company, reinsurer;
- any insurance broker or benefit plan administrator, my employer or former employer and any of their agents performing services relating to any employee benefits;
- any federal or provincial government agency, department or organization;
- any investigative or security agency, personal information agent or any other person, agency or institution having my Personal Information.

I understand that any Personal Information that I provide, or which Manulife Financial and/or SISIP Financial Services has collected, will be kept by Manulife Financial and/or SISIP Financial Services in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife Financial and/or SISIP Financial Services and other persons (corporate or individual), firms or agencies engaged by Manulife Financial and/or SISIP Financial Services, in the performance of their duties, as well as persons to whom I have granted access in writing, or to any other person authorized by law.

I understand that where Manulife Financial and/or SISIP Financial Services has obtained sensitive medical information from someone other than my physician, Manulife Financial and/or SISIP Financial Services will only release such information through my physician.

I understand and agree that this authorization shall continue as long as the claim for which this authorization has been completed exists, or services for this claim are required from Manulife Financial . A copy of this authorization shall be as valid as the original.

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

Schedule of Indemnities

Full Amount of Insurance for ***Regular Force*** members ***& Reserve Force Class C*** members = $250,000

Primary Reserve Force Class A and B:

Full Amount of Insurance for ***Class A and Short Term Class B*** members = $250,000

Full Amount of Insurance for ***Long Term Class B*** members = $250,000

Full amount of insurance for loss* of:

Both Hands
Both Feet
One Hand and One Foot
Sight of Both Eyes
One Hand and Sight of One Eye
One Foot and Sight of One Eye
Loss of Hearing
Loss of Speech

One half of the full amount of insurance for loss* of:

Sight of One Eye
One Hand
One Foot

One quarter of the full amount of insurance for loss* of:

Thumb and Index Finger of Same Hand

* "Loss" as used above shall also mean loss of use.

* "Loss" shall mean total and irrecoverable loss.

The total amount payable for all losses suffered by any one member and resulting from any one accident shall not exceed the full amount of the insurance.

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Attending Physician's Statement (APS)
Claim for Accidental Dismemberment Benefit Insurance Plan (ADIP) Benefit
Manulife Financial
Policy Number 906906

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Service No:	

Last Name of Patient:	Given Name(s):

Claim Details

1. Date first consulted on account of injury: _____ Day Month Year

2. Date patient last treated: _____ Day Month Year

3. Describe the exact nature, location and extent of injuries sustained:

4. A. If the accident caused the loss of an arm, hand, leg or foot or any part thereof, indicate the level of amputation here and on the chart on page 2.

   B. Date of Amputation: _____ Day Month Year

5. If the accident caused Quadriplegia, Paraplegia or Hemiplegia, date paralysis occurred: _____ Day Month Year

6. If the accident resulted in total and irrecoverable loss of sight of either or both eyes, date such loss occurred: _____ Day Month Year

   A. If the accident necessitated removal of either or both eyes, date of removal. _____ Day Month Year

   B. What was the vision in each eye prior to the accident?

      Left _____ Right _____

   C. What percentage of vision, if any, remains in each eye?

      Left _____ Right _____

7. If the accident resulted in total and irrecoverable loss of speech, date such loss occurred: _____ Day Month Year

8. If the accident resulted in total and irrecoverable loss of hearing in both ears, date such loss occurred: _____ Day Month Year

   A. What was the hearing in each ear prior to the accident?

      Left _____ Right _____

   B. What percentage of hearing, if any, remains in each ear?

      Left _____ Right _____

   C. Does hearing improve with the aid of a hearing aid? ☐ Yes ☐ No

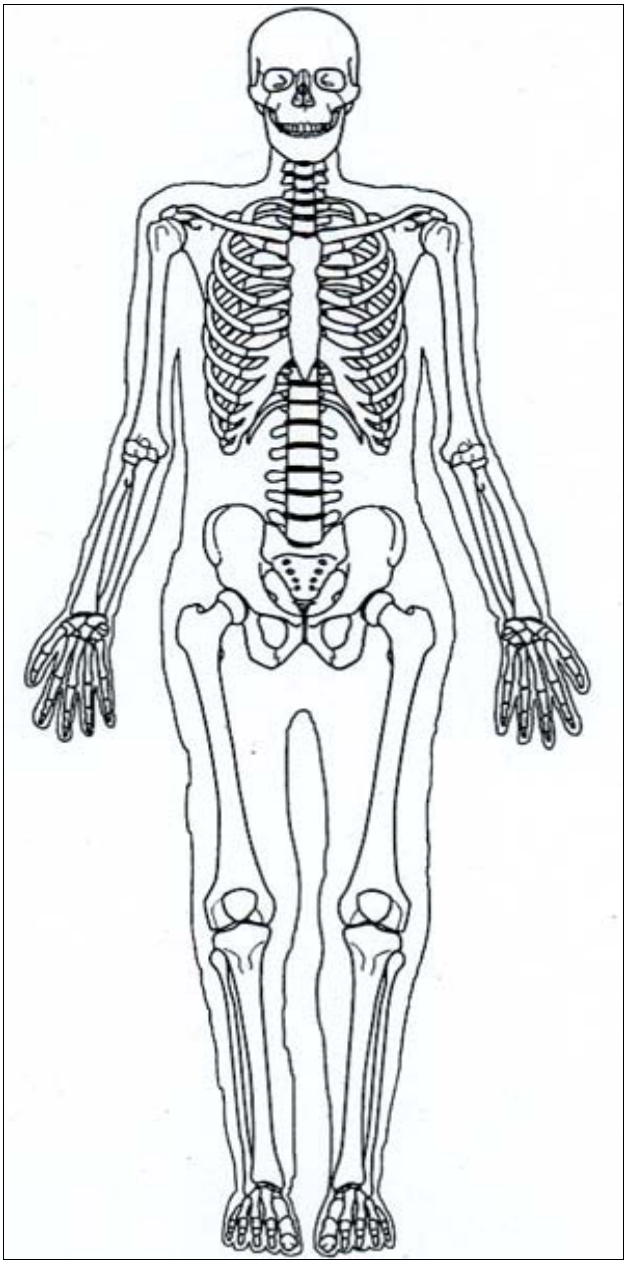
9. Was the injury described solely responsible for the loss? ☐ Yes ☐ No

   If "No", please give particulars of any contributing cause or causes.

Service No:

Part II: TO BE COMPLETED BY THE ATTENDING PHYSICIAN (continued):

Please indicate on chart at what level amputation was made:



Attending Physician's name (please print or attach business card)	Telephone No. of Attending Physician ( )
Address of Attending Physician	
Attending Physician's signature	Day Month Year