Claim for Accidental Dismemberment Benefit

Manulife Financial
Group Policy # 901102

A CLAIM CONSISTS OF SISIP FS INS 24E (PART I) PAGES 1 & 2 AND (PART II) PAGES 1 & 2

Instructions

Please complete and sign SISIP FS INS 24E, Part I — pages 1 & 2 and then have your attending physician complete 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 the answers, use separate sheets (indicate the Certificate Holder's name and Service Number) and attach them to the form.

Once the forms have been completed in their entirety, please mail them directly to Manulife Financial at the address below.

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

Accidental Dismemberment

Claimant Statement

Group Policy # 901102

Part I — To be completed by Certificate Holder:

1. Type of Coverage (Please check appropriate box)

- ☐ Optional Group Term Insurance (OGTI)*
- ☐ Reserve Term Insurance Plan (RTIP)*
- ☐ General Officer's Insurance Plan (GOIP)
- ☐ Reserve General Officer's Insurance Plan (Res-GOIP)
- ☐ Coverage After Release (CAR)
- ☐ Insurance for Released Members (IRM)

2. Person for whom this claim is being filed
(Please check appropriate box)

- ☐ Serving Member
- ☐ Spouse
- ☐ Child/Dependant
- ☐ Former Member
- ☐ Ex-Spouse

***Note**: For serving members under OGTI and RTIP, the accidental dismemberment must be non-attributable to military service. For accidental dismemberment which is attributable to military service, please refer to Group Policy # 906906—Claim Forms SISIP FS INS 12E & 13E.

3. Certificate Holder's Information

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

Mailing Address | ( ) Home Phone #

PO Box, Rural Route, etc. | ( ) (circle) work/cell phone/pager #

City | Prov. | Postal Code

4. Dismembered Person's Information (If not the certificate holder)

Surname | First Name | Initials | Relationship

Mailing Address (at the time of loss)

Day | Month | Year

Date of Birth

City | Prov. | Postal Code

5. Claim Details

A. According to the Schedule of Benefits (available on our website or call your local SISIP FS Representative for assistance), 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

For more information, please call 1-800-267-6681
or visit www.sisip.com

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Service Number (SN) of Certificate Holder:

5. Claim Details (continued)

D. Where accident occurred:

E. Give a brief description of the accident:

F. If this claim is for a serving member, explain why the Accidental Dismemberment is not attributable to military service:

6. Declaration and Authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that this claim may be denied as a result of 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 the dismembered person, including any information, records or other data concerning the dismembered person, the medical history and treatment, and past and present income, employment, education and training (collectively called “Personal Information”).

The 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 this 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 the 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, 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 the Personal Information.

I understand that any Personal Information that is provided, 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 the dismembered person’s physician, Manulife Financial and/or SISIP Financial Services will only release such information through the 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.

Signature of Certificate Holder | Day Month Year

Signature of Dismembered Person or Parent/Guardian (if under 18 yrs old) | Day Month Year

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Accidental Dismemberment

Attending Physician's Statement (APS)

Group Policy # 901102

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Service Number (SN) of Certificate Holder:

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.

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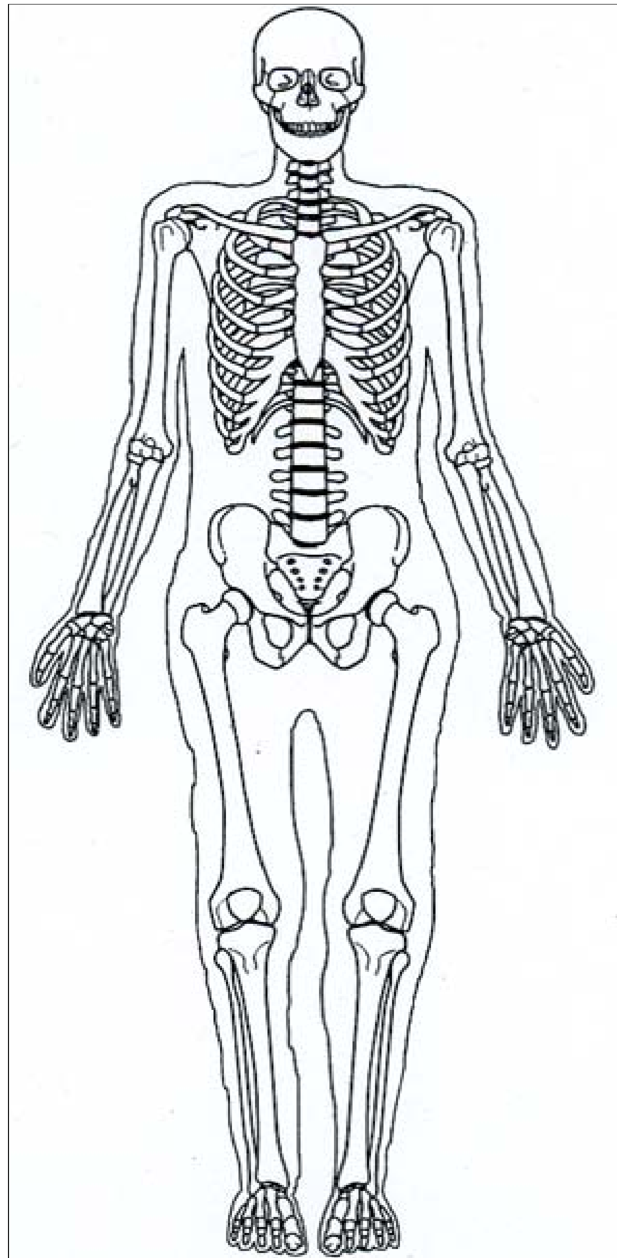
Part II: TO BE COMPLETED BY THE ATTENDING PHYSICIAN (continued):

Service Number (SN) of Certificate Holder:

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

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or visit www.sisip.com