FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Manulife Financial

Spousal Disability Plan Claim

Manulife Financial
Group Policy # 901107

A CLAIM CONSISTS OF SISIP FS INS 46E (PART I) PAGES 1 to 3, (PART II) PAGES 1 to 3

Instructions

Please complete and sign SISIP FS INS 46E, Part I — pages 1 to 3 and the Patient Authorization on Page 1 of Part II. Then have the attending physician complete Part II — pages 1 to 3.

Please note that you are responsible for any costs associated with the completion of the forms.

Once the forms have been completed in their entirety, please mail them directly to: Manulife Financial, SISIP Services, 2727 Joseph Howe Drive, PO Box 1030, Halifax, NS B3J 2X5

Eligibility Criteria

Please read the following to fully understand the eligibility criteria that must be met in order to qualify for benefits under the Spousal Disability Plan.

"Total disability" and "totally disabled" means the insured person has a severe and prolonged disease, injury or health condition diagnosable by accepted medical or psychiatric standards, which disease, injury or health condition has given rise to impairment(s) that meet all of the following criteria:

(i) the impairments are measurable by accepted medical or psychiatric examination, and diagnostic procedure, test and investigation; and

(ii) the insured person's attending medical specialist has confirmed in writing to the Insurer that:

  (a) the impairment(s) has existed for a period of at least six consecutive months; and,

  (b) the application of established medical guidelines leads reasonably to the conclusion the impairment(s) may be expected to last a minimum of a further twelve consecutive months; and

(iii) the appropriate treatments, medications and/or aids have been prescribed, taken and used properly by the insured person and failed to produce sufficient improvement of the impairment(s) to alleviate the total disability; and

(iv) where the impairment is a physical impairment it must:

  (a) prevent the insured person from engaging in all of the activities listed in two or more of the “Schedule of Activity Categories” provided in Annex A; or

  (b) render the insured person a paraplegic, quadriplegic, or hemiplegic.

(v) where the impairment is a psychiatric impairment it must:

  (a) prevent the insured person from understanding and processing information that is relevant to making a decision concerning his/her own health care, nutrition, shelter, clothing, hygiene, financial affairs, and prevent the insured person from appreciating the reasonably foreseeable consequences of a decision or lack of decision; and

  (b) meet the diagnostic criteria for a mental condition recognized by the Diagnostic and the Statistical Manual of Mental Disorders - most current edition.

“Impairment” means a loss or abnormality of body structure or of a physiological or psychological function.

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Spousal Disability Plan
Claimant Statement
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PART I: TO BE COMPLETED BY CERTIFICATE HOLDER

1. Certificate Holder's Information

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

Mailing Address | Home Phone # ( )

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

City | Prov. | Postal Code | Email Address

2. Claimant's Information (If not the certificate holder)

Surname | First Name | Initials

Mailing Address (if not the same as member) | Date of Birth: Day Month Year

City | Prov. | Postal Code

Is the claimant a member or former member of the Canadian Forces? ☐ No ☐ Yes ☐ "Yes", indicate Service Number (SN) _____

If claimant is a former member, indicate date of release: Day Month Year

3. Claimant Statement Details

A. Nature of Disability (diagnosis):

B. Date disability began: Day Month Year

C. Is your disability considered? ☐ Permanent ☐ Temporary

D. Has the impairment lasted, or is it expected to last, for a continuing period of at least 12 months? ☐ Yes ☐ No

E. How does your illness or injury prevent you from performing your usual daily activities? Please provide details:

Service Number (SN) of Certificate Holder:

3. Claimant Statement Details (continued)

F. i) Are you currently seeing a physician for your illness or injury? ☐ No ☐ Yes (Please indicate in Block 4).

ii) How often do you see him/her? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other _____

iii) Date you first saw him/her: Day Month Year

iv) Date you last saw him/her: Day Month Year

v) What type of treatment are you currently receiving (i.e. physiotherapy, medications, etc.)?

G. Have you seen any other doctor since your illness or injury began? ☐ No ☐ Yes (Please indicate in Block 4).

H. Have you filed a claim for disability benefits with a third party, i.e. automobile insurer? ☐ No ☐ Yes

If "Yes", with whom and what is the current status?

I. Number of children dependant upon you for support: _____

Name(s): _____

Date(s) of Birth: Day Month Year

J. Additional remarks: Please provide any further details which you feel would be helpful.

4. ATTENDING PHYSICIAN/SPECIALISTS

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

Service Number (SN) of Certificate Holder:

5. 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 Spousal Disability Plan 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 claimant, including any information, records or other data concerning the claimant, and the medical history and treatment (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 patient'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 Claimant (If other than the certificate holder)	Day Month Year

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Spousal Disability Plan
Attending Physician's Statement
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Manulife Financial

PATIENT/CLAIMANT AUTHORIZATION

Surname | First Name | Initials

I hereby authorize the release to Manulife Financial and SISIP Financial Services of any information in respect of this claim.

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

Patient/Claimant's Signature

Day Month Year

PART II: ATTENDING PHYSICIAN'S STATEMENT

Instructions:
1) Please print.
2) Return completed form and attachments to your patient/claimant or directly to Manulife Financial, SISIP Services Dept., 2727 Joseph Howe Drive, PO Box 1030, Halifax NS B3J 2X5.
3) **Any charge for completing this form is your patient/claimant's responsibility.**

1. DIAGNOSIS (Please attach copies of all relevant consultation reports)

A. Please list all active, significant medical conditions. DSM Categories/Terminology preferred. Terms such as "Anxiety", "Depression", "Stress", require qualification and description.

B. Was the above diagnosis confirmed by a medical specialist? ☐ No ☐ Yes (Please indicate in Block 5).

C. i) When did the patient/claimant first become significantly disabled on a functional basis following the above diagnosis? Provide details.

Day Month Year

ii) Has the impairment existed continuously for a period of at least six consecutive months? ☐ Yes ☐ No

2. TREATMENT

A. Date of hospital in-patient admission:

Day Month Year

B. Date of discharge:

Day Month Year

B. i) Nature of treatment (e.g. date and type or surgery, medical treatment including medication, type, dosage and frequency):

ii) Has the patient/claimant taken and used properly the appropriate treatments, medications and aids prescribed? ☐ Yes ☐ No

iii) What are your treatment plans?

Service Number (SN) of Certificate Holder:

PART II: ATTENDING PHYSICIAN'S STATEMENT (continued) . . .

3. FUNCTIONAL ABILITIES

A. If the patient/claimant has an active significant **physical** health problem, as listed in Block 1A, please answer the following questions (refer to the definitions of "Activity Categories" list on Annex A):

i) Is the patient/claimant capable of looking after his/her own personal care needs? ☐ Yes ☐ No

If not, please specify which personal care need(s) the patient/claimant is incapable of performing at this time. Provide details:

Eating ☐ Yes ☐ No Dressing ☐ Yes ☐ No Personal Hygiene ☐ Yes ☐ No

ii) Is the patient/claimant capable of walking 50 metres on level ground with the use of appropriate aids and assisting devices?

☐ Yes ☐ No

iii) Is the patient/claimant capable of performing general household activities? ☐ Yes ☐ No

If not, please specify which general household activity(ies) the patient/claimant is incapable of performing at this time. Provide details:

Child Care ☐ Yes ☐ No Food Preparation ☐ Yes ☐ No Home Care ☐ Yes ☐ No

B. If the patient/claimant has an active significant **psychiatric** diagnosis, as listed in Block 1A, please indicate your opinion with regards to the patient/claimant's present ability to make reasonably rational decisions with respect to the following (provide details):

i) Personal Health Care ☐ Yes ☐ No

ii) Nutrition ☐ Yes ☐ No

iii) Shelter ☐ Yes ☐ No

iv) Clothing ☐ Yes ☐ No

v) Hygiene ☐ Yes ☐ No

vi) Financial Affairs ☐ Yes ☐ No

vii) Is the patient/claimant able to appreciate and understand the reasonably foreseeable consequences of decisions associated with the above? ☐ Yes ☐ No (provide details)

Service Number (SN) of Certificate Holder:

PART II: ATTENDING PHYSICIAN'S STATEMENT (continued) . . .

4. PROGNOSIS

A. Please provide your opinion with regards to the patient/claimant's prognosis over the next year, presuming appropriate treatment and compliance with treatment recommendations:

B. Is/are the condition(s) expected to last a minimum of a further 12 months or longer? ☐ Yes ☐ No (Please provide details)

5. ADDITIONAL INFORMATION

Remarks:

6. ATTENDING PHYSICIAN/SPECIALISTS

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

7. ATTENDING PHYSICIAN'S DECLARATION AND SIGNATURE

I DECLARE that the information in this statement is true to the best of my knowledge.

Attending Physician's signature

Day Month Year

Schedule of Activity Categories

CATEGORY A:	*PERSONAL CARE*—Eating, dressing, and personal hygiene as those terms are defined; and

CATEGORY B:	*MOBILITY*— the ability to walk, using an aid if necessary, at least 50 metres on level ground; and

CATEGORY C:	*HOUSEHOLD ACTIVITIES*— child care, home care, and food preparation as those terms are defined.

DRESSING

Means the ability to get clothes from the closets and drawers and put them on and take them off including undergarments, outer garments, and the use of fasteners and braces, if worn. Included is the ability to put on ant take off any artificial limbs.

EATING

Means the ability to feed oneself once the meal has been prepared and made available. Feeding oneself is specifically the ability to bring food, including beverages, to your mouth, and your ability to chew and swallow food. Eating does not include the preparation of food.

PERSONAL HYGIENE

Means the ability to maintain oneself in a reasonably clean and sanitary condition. Also included is the ability to maintain continence, which means the ability to maintain control of urination and bowel movements, including one's ability to use incontinence and ostomy supplies or other devices such as catheters.

CHILD CARE

Means the ability to provide physical support and maintenance, such as dressing, feeding, clothing and bathing, to a child unable to maintain him or herself.

HOME CARE

Means the ability to perform general housekeeping type functions, including but not limited to shopping for food, vacuuming, dusting, washing dishes and laundry.

FOOD PREPARATION

Means the ability to prepare and serve basic meals.