



Long Term Disability (LTD) Claim Form



SISIP Financial 6E (04/2021) Protected "B" (when completed)





LONG TERM DISABILITY (LTD) CLAIM FORM

Group Policy #901102

Before submitting these forms, please ensure:

- 1. The "Claimant Statement", "Conditions of Benefits Agreement" and the "Disclosure and Waiver Authorization" are fully completed, signed and dated where appropriate.
- 2. The "Patient/Claimant Identification and Authorization" portion of the "Attending Physician's Statement" is to be completed, signed and then taken to the physician who is treating you/the member. The physician will send the completed form and associated documentation directly to Manulife.

Please note that LTD benefits will not be considered for payment until ALL of the documentation is submitted in the pre-paid envelope provided or mailed to:

Manulife 2727 Joseph Howe Drive PO Box 1030 Halifax, NS B3J 2X5

Attention: SISIP Services

Note: If pre-paid envelopes are required, please contact your DND Case Manager's office.

If you have any difficulty in completing this form please do not hesitate to contact Manulife for assistance at 1-800-565-0701.





INFORMATION CHECKLIST

Before you return this application package, did you remember to
☐ Sign the Claimant Statement?
☐ Sign the Disclosure and Waiver Authorization?
☐ Sign the Conditions of Benefits Agreement?
☐ Complete the contact information sheet?
☐ Sign the Patient/Claimant Identification and Authorization portion of the Attending Physician's Statement (APS)?
☐ Submit the Attending Physician's Statement portion to the Medical Officer?
☐ Attach a copy of your Canadian Forces (CF) Member Personal Resume Record (MPRR-490A)?
☐ Answer all sections and make any changes if necessary and check both sides of each page for completion?
Please consider the following in preparation for your meeting with the SISIP Vocational Rehabilitation Counselor:
Define your Second Career Goals.
Consider transferable skills, and retraining goals.
 Will you be participating in the Skills Completion Program (SCP)? Have you contacted them?
Courses/retraining you would like to take.
Course availability; start and end dates
Associated costs; tuition, supplies, travel
Prerequisite courses, if applicable.
How will retraining help you achieve your second career goals?
Is relocation necessary?
Have you discussed your second career goals with your family?
 As you are permitted, and encouraged, to work under the CAF LTD Plan, have you secured employment following release?
 Can Manulife Vocational Rehab Department provide short-term training/assistance to help you with a specific employment opportunity?

Should you have any questions, please contact us.





LONG TERM DISABILITY (LTD) CLAIM CLAIMANT STATEMENT

Group Policy #901102

PERSONAL INFORMATION

1. INSTRUCTIONS

This form is to be completed by the Canadian Forces member and submitted along with an Attending Physician's Statement.

Please note that you are responsible for providing proof that you are entitled to benefits and you are responsible for any fees your doctor may charge to provide this material. Benefits will not be considered for payment until all documentation is submitted to Manulife.

2. IDENTIFICATION (please print)

Last Name	First Name	Initial Female		
Address: Street & Number	Apt.	City		
Province	Postal Code	Home Telephone No.		
Work Telephone No.	Cell No.	E-mail Address		
Date of Birth (Day/Month/Year) Service Number	*Social Insurance Number Rank Regular Reserve	Military Occupation Number of Years Served		
Marital Status: Single Marr	Common-Law Other			
		*Required for Income Tax Purposes		
3. RELEASE INFORMATION				
Will you be Medically Released (3A/3B) fro	m the Canadian Forces? Yes	No		
What is your item of release?				
What is your expected Date of Release (DOR)? (Day/Month/Year)				

Please be advised, your completed LTD Claim Form must be returned and received by our office within 120 days of your Date of Release from the Canadian Forces.

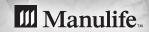




PERSONAL INFORMATION

. ACTIVE MEDICAL CONDITIONS		Service Number:	
Medical condition #1:		Date symptoms (Day / Month /	
If yes, please explain			
If condition is due to injury, Place:			Date: (Day / Month /Year)
Have you ever been hospitalized as a result of your condition? Yes If yes, name of hospital:	No (I	From: Day / Month /Year)	To: (Day / Month /Year)
Medical condition #2:		Date symptoms (Day / Month /	
If yes, please explain			
If condition is due to injury, Place:			Date: (Day / Month /Year)
Have you ever been hospitalized as a result of your condition? Yes If yes, name of hospital:	No (I	From: Day / Month /Year)	To: (Day / Month /Year)
Medical condition #3:		Date symptoms (Day / Month /	
If yes, please explain			Yes No
If condition is due to injury, Place:			Date: (Day / Month / Year)
Have you ever been hospitalized as a result of your condition? Yes If yes, name of hospital:	No (I	From: Day / Month /Year)	To: (Day / Month /Year)





PERSONAL INFORMATION

_	ATTENDING DUVCIOLAN INFORMATIO	ABI					
5.	ATTENDING PHYSICIAN INFORMATIO	VIV.	Service Number:				
	Names and addresses of all physicians, oth of your medical conditions.	ner than military medical o	officers, who you have seen for any				
Name: Address:							
6.	CURRENT ACTIVITIES						
tion, leave blank and your Manulife Case Manager will contact you. Please describe your daily routine since the onset of your medical condition: Given the description above, is this different from your routine prior to your medical condition? Yes No							
	What is your current treatment for your condition(s)?						





REHABILITATION						
. FUNCTIONAL	_ITY				Service Number:	
The following information will be used to determine if there are any factors that limit you from active participation in school or work. Please keep this in mind when completing this section. PHYSICAL:						
	are you cap No	able of perfo Limited (hours/day)	Complete	following functions:	Details	
Standing:						
Sitting:						
Walking:						
Squatting:						
Pushing:						
Pulling:						
Driving:						
Stair Climbing:						
	NAL STI			Carrying Over 5 20-50 lbs 10-20 lbs 5-10 lbs Under 5 lbs	0 lbs	ly Frequently Continuously
(1 = unable to perf	form/unable tasionally per	to cope with, 2 form/mildly d Banki Basic	2 = rarely per ifficult to cop ing/Money Personal Ca	manage/cope with the form/very difficult to cope we with, 5 = often perform/n	with, 3 = seldom perform	-day living
Did you have an	y difficulty o	completing/	understand	ing these questions?	Yes No	



2. EDUCATION



CLAIMANT STATEMENT

REHABILITATION

Service Number:

	Name of Educational Inst	itution Loc	ation	Grade Completed	Cert	Diploma/Degree
Primary:						
Secondary:						
College:						
University:						
Courses while in	the Canadian Forces		Course Cont	ent		Length
1.						
2.						
3.						
4.						
5.						
Other:						
1.						
2.						
3.						
WORK HIST	ORY					
	erience prior to Military Serv Employer	ice: Job/Position		Start Year		Duration

3.

4.

1.

2.

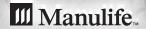




REHABILITATION

. ADDITIONAL QUESTIONS	Service Number:
1. What are your current plans upon release from the CF?	
If definite work plans:	·
a) Type of work:	
b) Employer:	
c) Earnings:	
2. What type of re-training/employment are you interested in?	
3. Are you willing to relocate to enhance your opportunities for retraining.	/employment? Yes No
4. Will you be relocating after release? Yes No Where?	
, ou de loiteauning and resource.	5.1.7.
OTHER INFORM	ATION
1. If any of your medical conditions are the result of an accident/motor ve	ehicle accident. are you taking action against a third party?
Yes No	
2. Are criminal charges pending? Yes No	
3. If yes, lawyer's name:	Phone No
4. Lawyer's address:	
5. Name of insurance company:	





	OTHER INCOME					
		Service Number:				
The potential amount payable to me for any disability shall be calculated in accordance with the terms and conditions of the SISIP Group Policy #901102, which calculation shall allow for the deduction of other amounts related to any such disability. In addition to providing the information requested below, it is imperative that you notify us of any future change in the status of these benefits.						
Have you applied for:						
a) Canada/Quebec Pension Plan (CPP/QPP)	Yes No					
Current Status: Pending Approved	Denied Appealed (Please	provide copies of any corre	spondence received.)			
b) Other Benefits/Income (If applicable):	Amount Effective (Day / Mont		Details			
Civilian Employment Earnings Yes No						
Automotive Insurance Yes No						
Other Group Disability Benefits Yes No						
Worker's Compensation Yes No						
Other Employer Pension Plan Yes No						
 I authorize Manulife to correspond with me at the email address listed above. Correspondence may contain my personal information including, but not limited to, medical, employment and financial information. I understand that my personal information being sent via email is not guaranteed as a secured means of communication. I certify that all information given on this form is complete and true in every respect and is given for the purpose of securing Long Term Disability (LTD) benefits set forth by the LTD provision contained in the insurance agreement. 						
Dated this	day of	, 20				
Member's Signature: X						



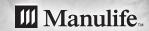


CONTACT INFORMATION

Upon receipt of the completed forms, we may contact each member by phone to complete the assessment of their Long Term Disability claim. Please indicate a convenient time(s) and weekday(s) so that we may contact you. Please provide a telephone number for the times indicated and **return this sheet** along with your completed Claimant Statement.

Time(s) available:	
Weekday(s) available:	
Telephone number(s) and e-mail address:	





Group Policy #901102

CONDITIONS OF BENEFITS AGREEMENT

CI	aimant's Name:		Service N	lumber:
То	:The Manufacturers Life Insurance	Company ("Manuli	fe,""the Company")
1.	and conditions of SISIP Group Policy # amounts related to any such disability Plan, Quebec Pension Plan, Canadian (GECA), Worker's Compensation legisl Sources"). I further understand that the	#901102 (the "Policy"), , including, but not lim Forces Superannuatio ation, and automobile e purpose of this agre amounts from the Rele ns or personal represe	which calculation shanited to, amounts applied Act (CFSA), Governing insurance (public or plement is to allow the evant Sources, while rentatives any overpay	Il allow for the deduction of other roved or awarded by Canada Pension ment Employee Compensation Act private) (collectively, "Relevant Company to pay me the full amount eserving the Company's right to collect
2.	I AGREE that if any amounts are appro executors, administrators or personal paid under the Policy immediately, and The Company shall have the sole discr	representatives, will r d hereby indemnify an	eimburse the Compared hold the Company	ny for any overpayment of the amounts harmless from such overpayment(s).
3.	I FURTHER AGREE to make immediate application, I will immediately repay th Sources, had I applied. I understand th the Company reserves the right to esti	ne company the total a nat if the potential spec	amount(s) which woul cific amounts from the	d have been payable from the Relevant e Relevant Sources are not available,
4.	I FURTHER AGREE to notify the Compa amount(s) approved or awarded from			of any notification concerning any
5.	INTHE EVENT I fail or am unable to no Quebec Pension Plan, Canadian Forces Workers' Compensation organization, to the Company full details of any amelectronic reproduction of this agreem information referred to in this Agreement	s Superannuation Act and/or automobile ins ount(s) approved or a ent to those organizat	(CFSA), <i>Government</i> surance (public or priv warded. The provision	Employee Compensation Act, any vate) to release to the Policyowner and n of a photocopy, facsimile or other
6.	I FURTHER UNDERSTAND that the Corinterrupt my monthly payments becau			
tha	this agreement is signed in the province at they have requested that the present at demandé à ce que la présente conven	Agreement be drafted	d in English. Les partie	
Si	gned at	_ this	day of	, 20
Cı	aimant′s Signature: X		X	
U	aimant s signature: ==		Witness S	Signature

Claimant Statement (Page 9 of 10)

Witness name



Manulife_m

CLAIMANT STATEMENT

Group Policy #901102

DISCLOSURE AND WAIVER AUTHORIZATION

I expressly authorize and direct Manulife and/or SISIP Financial Services to release to any physician, hospital, the Canada Pension Plan, the Quebec Pension Plan, Veterans Affairs Canada, Workers' Compensation Board, *Government Employment Compensation Act* authority and the Group Master Policyowner all medical information in their possession including but not limited to, hospital records and reports, physician's statements, admissions histories, clinic records, X-rays and laboratory findings, any and all relevant medical histories pertaining to the undersigned who is insured under Manulife, SISIP Group Policy #901102.

I hereby authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to Manulife and/or SISIP Financial Services any such information.

I expressly release Manulife and/or SISIP Financial Services and the Department of National Defence from any and all liability in connection with their release of such information.

Additionally, in the event I am supported by the SISIP Vocational Rehabilitation Program (VRP), I hereby authorize any educational institution, training facility or organization involved in my vocational retraining to release all information and records concerning my academic standing, academic performance, attendance and participation to the SISIP Rehabilitation Department of Manulife.

This authorization is to be valid for the duration of my claim and any subsequent liability resulting from such a claim under the above reference policy.

I also authorize Manulife and/or SISIP Financial Services and the Group Master Policyowner to release any personal information to a third party where necessary for the proper adjudication and audit of my claim or the administration of the policy.

The information provided on this form is protected from unauthorized disclosure under *Canada's Privacy Act, Personal Information Protection and Electronic Documents Act* or equivalent provincial legislation and is available to you upon request.

A photocopy of the authorization shall be as valid as the original.

Dated this	day of	 20
Claimant's Signature:		
Please print your name:		
Witness:	Y	
withess signature:	^	





LONGTERM DISABILITY (LTD) CLAIM ATTENDING PHYSICIAN'S STATEMENT (APS)

INSTRUCTIONS

- 1. The "Patient/Claimant Identification and Authorization" section must be completed by the patient/claimant.
- 2. The remainder of the form must be completed by you, the treating physician, and submitted in the pre-paid envelope provided or mailed directly to:

Manulife 2727 Joseph Howe Drive PO Box 1030 Halifax, NS B3J 2X5

Attention: SISIP Services

PLEASE BE ADVISED

The Patient/Claimant is responsible for any fee associated with the completion of this and/or any future Attending Physician's Statement.



PATIENT/CLAIMANT'S NAME:



LONG TERM DISABILITY ATTENDING PHYSICIAN'S STATEMENT (APS)

Group Policy #901102

PART A - PATIENT/CLAIMANT IDENTIFICATION and AUTHORIZATION

- to be completed by the patient/claimant

Last Name	First Name	Initial I	Date of Birth (Day/Month/Year)
Address: Street & Number			Apt.
City	Province		Postal Code
Authorization:			
I Hereby Authorize the release of any information	on requested in respect of this claim to Manul	ife, SISIP FS and the C	Group Master Policyowner.
X			
Patient/Claimant's Signature	Service Number		Date (Day/Month/Year)
PLEASE BE ADVISED, The Patient/Claimant Physician's Statement.	is responsible for any fee associated with	the completion of	this and/or any future Attending
·			
PART B — ATTENDING PHYSICIA	AN'S STATEMENT		
	•	f various occupations.	
DIAGNOSIS – (Please do not use s Please provide copies of any relevant medic summaries, operative reports) that you belie	al evidence (e.g., specialist consultation le	tters, assessment rep	ports, hospital discharge
Current primary disabling diagnosis:			
Active physical health conditions (other than above primary diagnosis):			
Active psychiatric conditions			
(other than above primary diagnosis):			
List your patient's active symptoms:			
, , , , , , , , , , , , , , , , , , , ,			

#1 Diagnosis continues on next page. Please fill out both sections.





Group Policy #901102

1. DIAGNOSIS - Continued (Please do not use subjective descriptions i.e. pain, etc.)

	st your patient's active, objective inical findings:					
	st all relevant, objective investigation sults with corresponding dates:					
Do	you plan to refer this individual to any s	pecialists? Ye	s 🗌 No 🗌			
Sr	pecialist's Name	Specia	ality	Da	ate of Planned Visit	(Day/Month/Year)
Ė			,			
 2. C	OMPETENCY					
Is yo	ur patient competent to endorse cheques and o	lirect use of the pro	ceeds? Yes No	f no, from wha		Month/Year)
3. H	IISTORY					
Oı	n what date did symptoms first appear or	the accident hap	ppen?		(Day/Month/Year)	
Da	ate of first treatment:				(Day/Month/Year)	
Ha	as patient/claimant ceased to work due to	nis/her condition	? Yes No		(Day/Month/Year)	
	the 12 months preceeding the most rece me or a similar condition? Yes	nt onset of symp	toms, has the patient/cla	imant been t	reated or diagnose	d with the
If	yes, explain, including dates:					
	ave you completed any Workers' Compensions of absence?		other Insurance medical	application as	s a result of the mo	st
Сι	ırrent Height	Current Weight				





Group Policy #901102

4. CURRENT PHYSICAL FUNCTIONAL IMPAIRMENTS

Class 2 - Class 3 Class 4 Class 5	- capable o - capable o - capable o - not capa	f moderate of of light occup of sedentary ble of any ty	upational active ccupational activite oational activite occupational appe of gainful e patient's physicatient's	tivities ties activities mployment	ition(s) on his/her present ability to work:
Task No li	mitation	Limited Duration	Limited Frequency	Completely Limited	Reason/ Limitation
Standing:					
Sitting:					
Walking:					
Lifting:					
Carrying:					
Squatting:					
Climbing:					
Pushing:					
Pulling:					
Driving:					





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5. CURRENT PSYCHIATRIC FUNCTIONAL IMPAIRMENTS

Class 2 – mild symptoms and occupational de Class 3 – moderate symptoms and occupation Class 4 – severe symptoms and occupation	ional dysfunction
5. TREATMENT – Please indicate which of the including dosage, therapies	e following treatments are currently followed. Indicate active medications
	moraling frequency, etc.
Medication (Drug/Dosage)	1.
	2.
	3.
	4.
	5.
	6.
Physiotherapy (Frequency/Clinic)	
Psychotherapy (Frequency/Psychotherapist)	
Surgery (Type/Surgeon)	
Other (please specify)	
Is patient/claimant compliant with recommended	treatment? Yes No
If no, explain:	
As a result of treatment, the patient/claimant's condi	ition has: Improved Deteriorated Remained the same Stabilized
Comments: (future treatment options, expected out	comes, etc.)





Group Policy #901102

7. MEDICAL FITNESS FOR VOCATIONAL REHABILITATION/RETURN TO WORK

B) Has you	r patient expressed	l a desire to return to	o work? Yes 🗌 No	please commer	it	
) What do	you think is requi	red to enable your p	patient to return to w	ork?		
To own	occupation					
To any	other occupation					
)) What are	e your patient's sp	ecific restrictions/lim	nitations			
		additional details w	hich would be helpfu	l to our assessment	of your patient/client's lin	nitations or emplo
Other rem	narks:					
Other rem Thank you rour patier a) Test b) Clir	narks: for your cooperatint's file: t results, including	on in completing this but not limited to, b e date of first visit fo		with our evaluation G, stress tests, MRI,	, please provide copies of	
Other rem Thank you your patien a) Test b) Clin c) Spe	narks: for your cooperating tresults, including nical notes from the	on in completing this but not limited to, b e date of first visit fo n reports.	s form. To fully assist	with our evaluation G, stress tests, MRI,	, please provide copies of	
Other rem Thank you your patien a) Test b) Clin c) Spe	for your cooperati nt's file: t results, including nical notes from the cialist consultation	on in completing this but not limited to, b e date of first visit fo n reports.	s form. To fully assist	with our evaluation G, stress tests, MRI,	, please provide copies of	
Other rem Thank you rour patier a) Test b) Clir c) Spe	for your cooperati nt's file: t results, including nical notes from the cialist consultation	on in completing this but not limited to, b e date of first visit fo n reports.	s form. To fully assist	with our evaluation G, stress tests, MRI, on(s).	, please provide copies of	
Other rem Thank you your paties a) Test b) Clir c) Spe Name of A	for your cooperati nt's file: t results, including nical notes from the cialist consultation	on in completing this but not limited to, b e date of first visit fo n reports.	s form. To fully assist	with our evaluation G, stress tests, MRI, on(s).	, please provide copies of	