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Long Term Disability (LTD) Claim Form

SISIP.com

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

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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.

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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.

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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 | ☐ Male ☐ 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) | *Social Insurance Number | Military Occupation

Service Number | Rank | Regular ☐ Reserve ☐ Canadian Forces Component | Number of Years Served

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common-Law ☐ Other

*Required for Income Tax Purposes

3. RELEASE INFORMATION

Will you be Medically Released (3A/3B) from 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.

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CLAIMANT STATEMENT

PERSONAL INFORMATION

4. ACTIVE MEDICAL CONDITIONS

Service Number:

Medical condition #1:

Date symptoms started (Day / Month /Year)

Is this condition work related? Yes ☐ No ☐

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 ☐ No ☐
If yes, name of hospital:

From: (Day / Month /Year)

To: (Day / Month /Year)

Medical condition #2:

Date symptoms started (Day / Month /Year)

Is this condition work related? Yes ☐ No ☐

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 ☐ No ☐
If yes, name of hospital:

From: (Day / Month /Year)

To: (Day / Month /Year)

Medical condition #3:

Date symptoms started (Day / Month /Year)

Is this condition work related? Yes ☐ No ☐

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 ☐ No ☐
If yes, name of hospital:

From: (Day / Month /Year)

To: (Day / Month /Year)

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CLAIMANT STATEMENT

PERSONAL INFORMATION

5. ATTENDING PHYSICIAN INFORMATION

Service Number:

Names and addresses of all physicians, other than military medical officers, who you have seen for any of your medical conditions.

Name:	Address:

6. CURRENT ACTIVITIES

Complete this section to the best of your knowledge. If you experience difficulty filling out the information, 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** ☐

If yes, what activities did you do previously that you cannot do now?

What is your current treatment for your condition(s)?

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CLAIMANT STATEMENT

REHABILITATION

1. FUNCTIONALITY

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:

To what degree are you capable of performing the following functions:

Function	No Limitation	Limited (hours/day)	Complete Limitation	Details
Standing:				
Sitting:				
Walking:				
Squatting:				
Pushing:				
Pulling:				
Driving:				
Stair Climbing:				

	Never	Occasionally	Frequently	Continuously		Never	Occasionally	Frequently	Continuously
Lifting Over 50 lbs	☐	☐	☐	☐	Carrying Over 50 lbs	☐	☐	☐	☐
20-50 lbs	☐	☐	☐	☐	20-50 lbs	☐	☐	☐	☐
10-20 lbs	☐	☐	☐	☐	10-20 lbs	☐	☐	☐	☐
5-10 lbs	☐	☐	☐	☐	5-10 lbs	☐	☐	☐	☐
Under 5 lbs	☐	☐	☐	☐	Under 5 lbs	☐	☐	☐	☐

OPERATIONAL STRESS INJURY / PSYCHOLOGICAL:

On a scale of 1 to 5, rate yourself or your ability to manage/cope with the following aspects of daily living:
(1 = unable to perform/unable to cope with, 2 = rarely perform/very difficult to cope with, 3 = seldom perform/somewhat difficult to cope with, 4 = occasionally perform/mildly difficult to cope with, 5 = often perform/no difficulty coping)

Daily Errands	☐	Banking/Money	☐	Handling day-to-day living	☐
Household Chores	☐	Basic Personal Care	☐	Handling Stress	☐
Self Esteem	☐	Involvement in Leisure Activities	☐	Involvement in Work/School	☐

Did you have any difficulty completing/understanding these questions? Yes ☐ No ☐

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CLAIMANT STATEMENT

REHABILITATION

2. EDUCATION

Service Number:

	Name of Educational Institution	Location	Grade Completed	Cert/Diploma/Degree
Primary:				
Secondary:				
College:				
University:				

Courses while in the Canadian Forces	Course Content	Length
1.		
2.		
3.		
4.		
5.		

Other:

1.
2.
3.

3. WORK HISTORY

Employment Experience prior to Military Service:

Employer	Job/Position	Start Year	Duration

Job Experience in the Canadian Forces

1.	3.
2.	4.

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CLAIMANT STATEMENT

REHABILITATION

4. 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?* City:

OTHER INFORMATION

1. If any of your medical conditions are the result of an accident/motor vehicle 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:

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CLAIMANT STATEMENT

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 correspondence received.)

b) Other Benefits/Income (If applicable):

			Amount	Effective Date (Day / Month / Year)	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 _____

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CLAIMANT STATEMENT

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:

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CLAIMANT STATEMENT

Group Policy #901102

CONDITIONS OF BENEFITS AGREEMENT

Claimant's Name: _____ **Service Number:** _____

To: The Manufacturers Life Insurance Company ("Manulife," "the Company")

1. I understand that the potential amount payable to me for any disability shall be calculated in accordance with the terms and conditions of SISIP Group Policy #901102 (the "Policy"), which calculation shall allow for the deduction of other amounts related to any such disability, including, but not limited to, amounts approved or awarded by Canada Pension Plan, Quebec Pension Plan, *Canadian Forces Superannuation Act* (CFSA), *Government Employee Compensation Act* (GECA), Worker's Compensation legislation, and automobile insurance (public or private) (collectively, "Relevant Sources"). I further understand that the purpose of this agreement is to allow the Company to pay me the full amount under the Policy pending approval of amounts from the Relevant Sources, while reserving the Company's right to collect from me or my heirs, executors, assigns or personal representatives any overpayment of amounts under the Policy resulting from the approval of amounts from the Relevant Sources.

2. I AGREE that if any amounts are approved or awarded to me from the Relevant Sources, I or, if applicable, my heirs, executors, administrators or personal representatives, will reimburse the Company for any overpayment of the amounts paid under the Policy immediately, and hereby indemnify and hold the Company harmless from such overpayment(s). The Company shall have the sole discretion to determine whether an overpayment has occurred.

3. I FURTHER AGREE to make immediate application for amounts from the Relevant Sources and if I fail to make such application, I will immediately repay the company the total amount(s) which would have been payable from the Relevant Sources, had I applied. I understand that if the potential specific amounts from the Relevant Sources are not available, the Company reserves the right to estimate the potential amounts from the Relevant Sources.

4. I FURTHER AGREE to notify the Company in writing, within 30 days, of my receipt of any notification concerning any amount(s) approved or awarded from the Relevant Sources.

5. IN THE EVENT I fail or am unable to notify the Company as required by Clause 4, I authorize the Canada Pension Plan, Quebec Pension Plan, *Canadian Forces Superannuation Act* (CFSA), *Government Employee Compensation Act*, any Workers' Compensation organization, and/or automobile insurance (public or private) to release to the Policyowner and to the Company full details of any amount(s) approved or awarded. The provision of a photocopy, facsimile or other electronic reproduction of this agreement to those organizations shall be sufficient authority for the release of this information referred to in this Agreement.

6. I FURTHER UNDERSTAND that the Company may, in accordance with the Policy and this Agreement, adjust, reduce or interrupt my monthly payments because of the amounts approved or awarded by the Relevant Sources.

If this agreement is signed in the province of Quebec, IT IS AGREED AND UNDERSTOOD that the parties herein recognize that they have requested that the present Agreement be drafted in English. Les parties à la présente reconnaissent qu'elles ont demandé à ce que la présente convention soit rédigée en anglais.

Signed at _____ **this** _____ **day of** _____**, 20**_____**.**

Claimant's Signature: **X** _____

X _____
Witness Signature

Witness name

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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: **X** _____

Please print your name: _____

Witness: _____

Witness Signature: **X** _____

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LONG TERM 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.

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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

PATIENT/CLAIMANT'S NAME:

Last Name	First Name	Initial	Date of Birth (Day/Month/Year)

Address: Street & Number **Apt.**

City	Province	Postal Code

Authorization:

I Hereby Authorize the release of any information requested in respect of this claim to Manulife, SISIP FS and the Group Master Policyowner.

Patient/Claimant's Signature	Service Number	Date (Day/Month/Year)
X		

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.

PART B — ATTENDING PHYSICIAN'S STATEMENT

1. This form is designed to:
   a) Obtain objective medical information regarding your patient/claimant's functional abilities; and
   b) Allow Manulife to apply your patient/claimants's impairment to the requirements of various occupations.
2. Your patient/claimant is responsible for any charge for the completion of this form.
3. Completion of this form will allow us to determine a reasonable schedule for medical updates. This will reduce the number of future requests to you.

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

Please provide copies of any relevant medical evidence (e.g., specialist consultation letters, assessment reports, hospital discharge summaries, operative reports) that you believe may be helpful in clarifying your patient's health status.

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.

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ATTENDING PHYSICIAN'S STATEMENT (APS)

Group Policy #901102

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

List your patient's active, objective clinical findings:

List all relevant, objective investigation results with corresponding dates:

Do you plan to refer this individual to any specialists? **Yes** ☐ **No** ☐

Specialist's Name	**Speciality**	**Date of Planned Visit (Day/Month/Year)**

2. COMPETENCY

Is your patient competent to endorse cheques and direct use of the proceeds? **Yes** ☐ **No** ☐ If no, from what date? **(Day/Month/Year)**

3. HISTORY

On what date did symptoms first appear or the accident happen? **(Day/Month/Year)**

Date of first treatment: **(Day/Month/Year)**

Has patient/claimant ceased to work due to his/her condition? ☐ **Yes** ☐ **No** **(Day/Month/Year)**

In the 12 months preceeding the most recent onset of symptoms, has the patient/claimant been treated or diagnosed with the same or a similar condition? ☐ **Yes** ☐ **No**

If yes, explain, including dates:

Have you completed any Workers' Compensation, C/QPP or other Insurance medical application as a result of the most recent period of absence? ☐ **Yes** ☐ **No**

Current Height Current Weight

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ATTENDING PHYSICIAN'S STATEMENT (APS)

Group Policy #901102

4. CURRENT PHYSICAL FUNCTIONAL IMPAIRMENTS

- ☐ **Class 1 – capable of heavy occupational activities**
- ☐ **Class 2 – capable of moderate occupational activities**
- ☐ **Class 3 – capable of light occupational activities**
- ☐ **Class 4 – capable of sedentary occupational activities**
- ☐ **Class 5 – not capable of any type of gainful employment**

Describe the specific effects of your patient's physical health condition(s) on his/her present ability to work:

Task	**No limitation**	**Limited Duration**	**Limited Frequency**	**Completely Limited**	**Reason/ Limitation**
Standing:	☐	☐	☐	☐	
Sitting:	☐	☐	☐	☐	
Walking:	☐	☐	☐	☐	
Lifting:	☐	☐	☐	☐	
Carrying:	☐	☐	☐	☐	
Squatting:	☐	☐	☐	☐	
Climbing:	☐	☐	☐	☐	
Pushing:	☐	☐	☐	☐	
Pulling:	☐	☐	☐	☐	
Driving:	☐	☐	☐	☐	

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ATTENDING PHYSICIAN'S STATEMENT (APS)

Group Policy #901102

5. CURRENT PSYCHIATRIC FUNCTIONAL IMPAIRMENTS

- ☐ **Class 1 – absent or minimal symptoms and essentially normal occupational functioning**
- ☐ **Class 2 – mild symptoms and occupational dysfunction**
- ☐ **Class 3 – moderate symptoms and occupational dysfunction**
- ☐ **Class 4 – severe symptoms and occupational dysfunction**

Describe the specific effects of your patient's psychiatric condition(s) on his/her present ability to work:

6. TREATMENT – *Please indicate which of the following treatments are currently followed. Indicate active medications including dosage, therapies including 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 condition has: Improved ☐ Deteriorated ☐ Remained the same ☐ Stabilized ☐

Comments: (future treatment options, expected outcomes, etc.)

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ATTENDING PHYSICIAN'S STATEMENT (APS)

Group Policy #901102

7. MEDICAL FITNESS FOR VOCATIONAL REHABILITATION/RETURN TO WORK

A) In your opinion, is your patient medically fit to participate in a vocational rehabilitation program or return to work?

B) Has your patient expressed a desire to return to work? Yes ☐ No ☐ please comment

C) What do you think is required to enable your patient to return to work?

☐ To own occupation

☐ To any other occupation

D) What are your patient's specific restrictions/limitations

8. REMARKS – *Provide any additional details which would be helpful to our assessment of your patient/client's limitations or employment*

Other remarks:

Thank you for your cooperation in completing this form. To fully assist with our evaluation, please provide copies of the following from your patient's file:

a) Test results, including but not limited to, blood work, x-rays, EKG, stress tests, MRI, etc.
b) Clinical notes from the date of first visit for the present condition(s).
c) Specialist consultation reports.

Name of Attending Physician (PLEASE PRINT)

Specialty **Telephone No.** __ __ __ __ __ __ __ __ __ __

Address:

Street **City** **Province** **Postal Code**

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.

Physician's Signature X **Date: (D/M/Y)**