Attending Physician's Statement (APS)

Waiver of Life Insurance Premiums

Manulife Financial
Group Policy # 901102

Part I — TO BE COMPLETED BY PATIENT/CLAIMANT

Waiver of Premium claim No. ____________

1. MEMBER INFORMATION

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

Mailing Address | Home Phone # ( )

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

City | Province | Postal Code | Email address

2. DECLARATION AND AUTHORIZATION BY PATIENT/CLAIMANT

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 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.

Patient/Claimant's Signature ____________ Day Month Year ____________

For more information, please call 1-800-565-0701
or visit www.sisip.com

Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN

INSTRUCTIONS TO PHYSICIAN

Please provide all information and documentation as required on this form so that we can better understand the extent of your patient/claimant's illness and the resulting impairments. The information provided will form the basis upon which continuing entitlement to benefits will be assessed.

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**.

Patient/Claimant Identification:

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

1. HISTORY (to be completed with initial claim only)

A) Date symptoms first appeared or accident happened. ______ Day Month Year

B) Date patient ceased work because of current condition. ______ Day Month Year

C) Date of first treatment. ______ Day Month Year

D) Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes, state and describe.

______

______

2. DIAGNOSIS

A) Primary ______

______

B) DSM IV terminology and codes: Axis I ______

Axis II ______ Axis III ______

Axis IV ______ Axis V ______

C) Secondary ______

______

D) Objective findings ______

E) Subjective findings ______

F) Please provide copies of the following documents in support of the stated diagnosis

☐ consultation notes ☐ test/investigation reports ☐ assessment reports ☐ psychological testing reports ☐ operative reports

☐ hospital admission history ☐ discharge summary ☐ clinical notes ☐ other ______

G) Current weight ______ lbs / kgs Current blood pressure (if cardiac diagnosis) ______

3. SYMPTOMS

Please state all current symptoms on which your diagnosis is based ______

______

______

______

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Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN (CONTINUED)

Service Number (SN):

4. CURRENT IMPAIRMENTS—PHYSICAL

I) ☐ Class 1 (no impairments—capable of strenuous physical activity)
☐ Class 2 (slight limitation—capable of moderate activity)
☐ Class 3 (moderate limitation—capable of light activity)
☐ Class 4 (marked limitation—capable of minimal activity)
☐ Class 5 (severe limitation—incapable of minimal activity)

II) Is you patient capable of:
☐ Lifting ____________ lbs / kgs
☐ Sitting ☐ Standing
☐ Walking ☐ Bending
☐ Squatting ☐ Climbing

III) Is your patient: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

IV) Does your patient require assistive devices? If yes, please specify ____________________

5. CURRENT IMPAIRMENTS—PSYCHIATRIC

I) ☐ Class 1 (able to function under stress and engage in interpersonal relationships—no limitation)
☐ Class 2 (able to function under most stress situations and engage in most interpersonal relationships—slight limitation)
☐ Class 3 (able to engage in only limited stress situations and limited interpersonal relationships—moderate limitation)
☐ Class 4 (unable to engage in stress situations or engage in interpersonal relationships—marked limitation)
☐ Class 5 (patient has significant loss of psychological and social abilities—severe limitation)

II) How does your patient's psychiatric disorder affect his/her ability to work? Please provide specific restrictions and limitations ____________________

6. COMPLICATIONS

A) Please indicate any medical complications which are delaying your patient's recovery ____________________

B) Other factors influencing illness (for example—work issues, job loss, relationships, bankruptcy, family illness/death, loss of professional licence, etc.) ____________________

C) Is there an alcohol or substance problem? ☐ No ☐ Yes, please specify treatment centre and program details ____________________

7. TREATMENT

A) Current medications. Please specify names of drugs, dosages, start dates and durations ____________________

Response to treatment ____________________

B) Other treatment (for example—physiotherapy, psychotherapy, counselling, day treatment programs). Please specify type, place, frequency and full name of facility ____________________

C) Dates Hospitalized (recent) Admission Date ____________ (Day Month Year) Discharge Date ____________ (Day Month Year)

Institution ____________________ Reason ____________________

D) Compliance: Is your patient following the recommended treatment program? ☐ No ☐ Yes If no, please explain ____________________

E) Please state frequency of visits: ☐ weekly ☐ monthly ☐ other, please specify ____________________

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Part II — TO BE COMPLETED BY THE ATTENDING PHYSICIAN (CONTINUED)

Service Number (SN):

7. TREATMENT (continued)

F) Please provide details of any proposed treatment plan including any recommended surgery

G) Have you referred your patient to any other physician? ☐ No ☐ Yes, please provide the full name and specialty

8. PROGNOSIS

A) What do you understand your patient's occupation to be?

B) Are you familiar with the requirements of your patient's occupation? ☐ No ☐ Yes

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

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

☐ To own occupation

☐ To any other occupation

E) What are your patient's specific restrictions/limitations?

9. LICENCE RESTRICTION

Has your patient's professional licence certification, driver's or other licence been ☐ restricted, ☐ suspended, or ☐ revoked?

If yes, date ______ Specify the type of licence ______ Class of licence (if applicable)

Day Month Year

10. ADDITIONAL INFORMATION

A) Remarks

B) Have you provided medical information on your patient/claimant's behalf for other benefits? ☐ No ☐ Yes If yes, please provide the full name of the company

11. 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

12. 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

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