A division of CFMWS
Une division des SBMFC

Long Term Disability (LTD) Claimant Update

Group Policy # _______________

LTD Claim No. ___________

In providing long-term disability benefits, information is periodically collected about your current health and activities. This information is used to evaluate what additional rehabilitation, training or support options are needed and ensuring the benefit coverage remains appropriate.

1. MEMBER INFORMATION

Service Number (SN)	Surname	First Name	Initials

Mailing Address	Home Phone

PO Box, Rural Route, etc.	(circle) Work / Cell Phone

City	Province	Postal Code	Email address

2. CLAIMANT DETAILS

A. Since your last update, describe any changes to your medical condition(s) and/or new diagnoses:

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B. Since your last update, describe any changes to your level of functioning, abilities and limitations:

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C. Since your last update, describe any changes to your day to day indoor and outdoor activities including any hobbies and volunteering:

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D. Since your last update, what courses/training have you completed or are presently taking outside of the SISIP Vocational Rehabilitation program?

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E. Since your last update, have you been employed? If so please provide details with respect to dates of employment, wages earned, job description, etc.

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F. If you are not presently employed or participating in the SISIP Vocational Rehabilitation program:

i. What supports do you and/or your doctor believe could assist you with retraining or return to work?

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ii. Would you like to be contacted by a SISIP Vocational Rehabilitation Counsellor to discuss potential options that may be available for you under the program?

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2. CLAIMANT DETAILS (continued)

G. Are you receiving benefits from any of the following sources? If "Yes", indicate the monthly amount:

	Yes	Current Amount	No	If "No", have you made application for the benefit
i. Canada Pension Plan Retirement(CPP)/ Quebec Pension Plan Retirement/(QPP) (Claimant portion only)	☐	____________	☐	Yes ☐ No ☐
ii. Canada Pension Plan Disability(CPP-D) Quebec Pension Plan Disability(QPP-D) (Claimant portion only)	☐	____________	☐	Yes ☐ No ☐
iii. Canadian Forces Superannuation(CFSA)	☐	____________	☐	Yes ☐ No ☐
iv. Other (e.g. Old Age Security, pension income, motor vehicle insurance, other disability income, GECA, other)	☐	____________	☐	Yes ☐ No ☐

Please provide details for item iv: ______________________________

3. ATTENDING PHYSICIAN/SPECIALISTS (please print names and addresses)

Current Family Doctor:	
Address:	Telephone No.:
Current Primary Specialist, if applicable:	Specialty:
Address:	Telephone No.:
Other Specialists actively involved in your care:	

4. SIGNATURE

Declaration and Authorization by Applicant

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 and/or SISIP Financial to conduct such investigations concerning this claim for Long Term Disability benefits as they may require.
I understand that, during the course of their investigations, Manulife and/or SISIP Financial 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 and/or SISIP Financial 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; administering the policy under which my claim has been made; medical case study or review.
I therefore authorize Manulife, SISIP Financial 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 and/or SISIP Financial has collected, will be kept by Manulife and/or SISIP Financial in a confidential file, which will be disclosed only to Authorized Individuals. Authorized Individuals include employees of Manulife and/or SISIP Financial and other persons (corporate or individual), firms or agencies engaged by Manulife and/or SISIP Financial, 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 and/or SISIP Financial has obtained medical information from someone other than my physician, Manulife and/ or SISIP Financial 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. 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*, *Personal Information Protection and Electronic Documents Act* or equivalent provincial legislation and is available to you upon request.

______________________________   ______________________________
Claimant Signature   Day Month Year

Please return completed form to: Manulife, SISIP Services, 2727 Joseph Howe Drive, PO Box 1030, Halifax, NS B3J 2X5