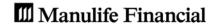


Waiver of Life Insurance Premiums Claimant Statement



Manulife Financial Group Policy # 901102

1. MEMBER'S INFORMATION						
Service Number (SN)	rname		First Name			Initials
				()	1	
Mailing Address				Home Pho	ne#	
				()		
PO Box, Rural Route, etc.				(circle) wor	rk/cell phone/pag	er#
City		Prov.	Postal Code	Email addr	ess	
2. SPOUSE'S INFORMATION (C	COMPLETE IF APPLICABLE,)				
Spouse's Full Name:						
Date of Birth:	Marital Status:	Marath Van	Date of Marriag	e/Co-habitation:	-	
Day Month Year	Day	Month Year			Day Mon	th Year
3. CLAIMANT STATEMENT DETA	AILS					
A. Nature of Disability (diagnosis):						
B. If disability was due to an accident, plea	ase give brief details:					
C. Date disability began:	D. Date	vou were first tre	eated for this illness	or iniury:		
	Month Year	,		-	Day Month	Year
E. Since your disability began, have you b	een:				Day Monai	1 001
i) Confined to bed?	□No □Yes					
ii) Confined to home?	□ No □ Yes					
iii) A patient at a hospital or sanitarium			to			
iii) A patient at a nospital of sanitanum	Y INO I TES, IIOIII _	Day Month	Year Day	Month Year		
F. What type of treatment are you currentl	v receiving (i.e. physiotherapy	medications et	tc 1?			
T. Timat type of a dament are you carrona	y receiving (i.e. priyeleulerapy	, modiodiono, oi				
-						
G. What are your present daily activities?	Please indicate your limitation	ons, restrictions a	and changes that occ	curred to your da	ilv life due to disa	ability:
G. What are your present daily activities?	Please indicate your limitation	ons, restrictions a	and changes that occ	curred to your da	ily life due to disa	ability:

PROTECTED B (when completed)

				Service Number	r (SN):	
CLAIMANT STATEMENT DE		D v				
	engaging in all occupations or employme		□ No			
f No, please explain.						
Do you expect to return to gainful em	ployment?					
so you expose to retain to gainiar on	proyment. — Ne — ree, imem.	Day Month	Year			
EMPLOYMENT, EDUCATION	N & TRAINING					
Name of Lock Employers		lah Tilla.				
vame of Last Employer:		JOD TITIE:				
Description of Job Duties (Please ind	icate any machines or equipment used):					
			Date last worked:			
				Day	Month	Year
·	to most recent occupation): Job Function/Title			Length of	of Employ	ment
Employment Experience (prior				Lagath	- f =l	
Employment Experience (prior Name of Last Employer				Length o	of Employ	ment
·				Length o	of Employ	ment
·				Length o	of Employ	ment
·				Length o	of Employ	ment
Name of Last Employer				Length o	of Employ	ment
·					of Employ	
Name of Last Employer Formal Education:	Job Function/Title					
Name of Last Employer Formal Education:	Job Function/Title					
Name of Last Employer Formal Education:	Job Function/Title					
Name of Last Employer Formal Education:	Job Function/Title					
Formal Education: School Name and City	Job Function/Title Highest Grade Level					
Name of Last Employer Formal Education: School Name and City Other courses or training (inclu	Job Function/Title Highest Grade Level uding those acquired while serving	in the Canadian	Forces):	Certifica	ite/Degree	9
Formal Education: School Name and City	Job Function/Title Highest Grade Level	in the Canadian	Forces):	Certifica		9
Name of Last Employer Formal Education: School Name and City Other courses or training (inclu	Job Function/Title Highest Grade Level uding those acquired while serving	in the Canadian	Forces):	Certifica	ite/Degree	9
Name of Last Employer Formal Education: School Name and City Other courses or training (inclu	Job Function/Title Highest Grade Level uding those acquired while serving	in the Canadian	Forces):	Certifica	ite/Degree	9

PROTECTED B (when completed)

PROTECTED B (when completed)

PROTECTED B (when completed) Service Number (SN): **INCOME INFORMATION** Are you receiving disability benefits from any of the following sources? If "Yes", indicate monthly amount. **Current Amount** If "No", have you made application for this benefit? Yes A. Canada Pension Plan (CPP) Yes No П П (claimant portion only) B. Quebec Pension Plan (QPP) Yes (claimant portion only) C. Other sources (including Wage Loss Replacement Worker's Compensation) Provide details for Item C above: ATTENDING PHYSICIAN/SPECIALISTS Current Attending Physician's name: (Please print) Telephone No. of Attending Physician Address of Attending Physician Current Specialist's name, if applicable: (Please print) Telephone No. of Specialist Address of Specialist **SIGNATURE** You must notify Manulife Financial/SISIP Financial Services promptly if: 1. Your medical condition improves so that you would be able to work, even through you have not yet returned to work; You go to work, whether as an employee or self-employed; 3. You are discharged from the hospital or you are now confined to the hospital; 4. You expect to be away from your usual place of residence for an extended period; 5. You move and change addresses or contact information. **Declaration and Authorization by Applicant** I understand that the furnishing of this form is not an admission of any liability on the part of SISIP Financial Services and/or Manulife Financial and requests all physicians, hospitals, pension boards and other authorities to furnish SISIP Financial Services and/or Manulife Financial full information regarding his/her medical history. In addition, I certify that all information given on this form is complete and true in every respect; I authorize SISIP Financial Services, Manulife Financial or its reinsurers, for underwriting, administration of insurance and claims paying purposes, to gather only the necessary information for the object of the file, from any person or organization that has personal information relating to me; and I also authorize SISIP Financial Services, Manulife Financial or its reinsurers, to disclose only the necessary personal information they have on me to the same persons or organizations specified in paragraph b. The information provided on this form is protected from unauthorized disclosure under Canada's Privacy Act and is available to you upon request. A photocopy of this authorization shall be as valid as the original.

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

Day

Day

Claimant's Signature

Witness Signature

Month

Month

Year

Year