Waiver of Life Insurance Premiums
Claimant Statement
Manulife Financial
Group Policy # 901102

Manulife Financial

1. MEMBER'S INFORMATION

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

Mailing Address | ( ) Home Phone #

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

City | Prov. | Postal Code | Email address

2. SPOUSE'S INFORMATION (*COMPLETE IF APPLICABLE)*

Spouse's Full Name: _____

Date of Birth: _____ (Day Month Year) Marital Status: _____ (Day Month Year) Date of Marriage/Co-habitation: _____ (Day Month Year)

3. CLAIMANT STATEMENT DETAILS

A. Nature of Disability (diagnosis): _____

B. If disability was due to an accident, please give brief details: _____

C. Date disability began: _____ (Day Month Year)

D. Date you were first treated for this illness or injury: _____ (Day Month Year)

E. Since your disability began, have you been:

i) Confined to bed? ☐ No ☐ Yes

ii) Confined to home? ☐ No ☐ Yes

iii) A patient at a hospital or sanitarium? ☐ No ☐ Yes, from _____ (Day Month Year) to _____ (Day Month Year)

F. What type of treatment are you currently receiving (i.e. physiotherapy, medications, etc.)? _____

G. What are your present daily activities? Please indicate your limitations, restrictions and changes that occurred to your daily life due to disability: _____

Service Number (SN):

3. CLAIMANT STATEMENT DETAILS (CONTINUED) . . .

H. Does your disability prevent you from engaging in all occupations or employment? ☐ Yes ☐ No

If No, please explain. _____

I. Do you expect to return to gainful employment? ☐ No ☐ Yes, when? _____ (Day Month Year)

4. EMPLOYMENT, EDUCATION & TRAINING

Name of Last Employer: _____ Job Title: _____

Description of Job Duties (Please indicate any machines or equipment used): _____

Date last worked: _____ (Day Month Year)

Employment Experience (prior to most recent occupation):

Name of Last Employer	Job Function/Title	Length of Employment

Formal Education:

School Name and City	Highest Grade Level	Certificate/Degree

Other courses or training (including those acquired while serving in the Canadian Forces):

Course	Content	Length of Course

Service Number (SN):

5. INCOME INFORMATION

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

	Yes	Current Amount	No	If "No", have you made application for this benefit?
A. Canada Pension Plan (CPP) (claimant portion only)	☐	_____	☐	Yes ☐ No ☐
B. Quebec Pension Plan (QPP) (claimant portion only)	☐	_____	☐	Yes ☐ No ☐
C. Other sources (including Wage Loss Replacement Worker's Compensation)	☐	_____	☐	Yes ☐ No ☐

Provide details for Item C above: _____

6. 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	

7. 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;
2. 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,

a. I certify that all information given on this form is complete and true in every respect;
b. 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
c. 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.

_____ _____
Claimant's Signature Day Month Year

_____ _____
Witness Signature Day Month Year

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