FINANCIÈRE SISIP FINANCIAL
A division of CFMWS
Une division des SBMFC

Manulife

# Claim for Advanced Benefit

Manulife
Group Policy # 901102

**A CLAIM CONSISTS OF THREE PARTS:**

Part I - CLAIMANT STATEMENT (pages 1 & 2)

Part II - ATTENDING PHYSICIAN'S STATEMENT (pages 1 & 2)

Part III - ADVANCED BENEFIT AGREEMENT FORM (one of A, B, or C)
- A) Insured Member Agreement (pages 1 & 2)
- B) Insured Spouse Agreement (pages 1 & 2)
- C) Insured Dependent Agreement (pages 1 & 2)

**Instructions:**

Please complete and sign:

Part I - Pages 1 & 2.

Part II - Patient Authorization on page 1, then have the attending physician complete the remainder of pages 1 & 2.

Part III - Pages 1 & 2 of the appropriate version (A, B, or C).

Please note that you are responsible for any costs associated with the completion of the forms.

Once the forms have been completed in their entirety, please mail them directly to Manulife at the address below:

Manulife
SISIP Services
2727 Joseph Howe Drive
PO Box 1030
Halifax, NS B3J 2X5

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# Advanced Benefit
# Part I - Claimant Statement
Group Policy # 901102

Manulife

**PART I: TO BE COMPLETED BY CERTIFICATE HOLDER**

## 1. Type of Coverage
(Please check appropriate box)

- ❑ Optional Group Term Insurance (OGTI)
- ❑ Reserve Term Insurance Plan (RTIP)
- ❑ General Officer's Insurance Plan (GOIP)
- ❑ Reserve General Officer's Insurance Plan (Res-GOIP)
- ❑ Coverage After Release (CAR)
- ❑ Insurance for Released Members (IRM)
- ❑ Military Post Retirement Life Insurance Plan (MPRLIP)
- ❑ Survivor Income Benefit (SIB) - (Dependent Life only)

## 2. Person for whom this claim is being filed
(Please check appropriate box)

- ❑ Serving Member
- ❑ Spouse
- ❑ Child/Dependant
- ❑ Retired/Released Member
- ❑ Ex-Spouse
- ❑ Deemed Member

## 3. Certificate Holder's Information

| Service Number (SN) | Rank | Date of Birth | Surname | First Name | Initials |
|---|---|---|---|---|---|
| | | | | | |

| Mailing Address | Home Phone |
|---|---|
| | |
| PO Box, Rural Route, etc. | (circle) Work / Cell |
| | |

| City | Prov. | Postal Code | SIN |
|---|---|---|---|
| | | | |

## 4. Patient's Information (If not the certificate holder)

| Surname | First Name | Initials | Relationship |
|---|---|---|---|
| | | | |

| Mailing Address (if not the same as member) | | | Date of Birth |
|---|---|---|---|
| | | | |
| City | Prov. | Postal Code | Day Month Year |
| | | | |



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

Service Number (SN) of Certificate Holder:

## 5. Declaration and Authorization

I certify that the information in this form is true and complete, to the best of my knowledge. I understand that this claim may be denied as a result of providing false, incomplete or misleading information.

I authorize Manulife and/or SISIP Financial to conduct such investigations concerning this claim for advanced benefit 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 the patient, including any information, records or other data concerning the patient, and the medical history and treatment (collectively called "Personal Information").

The 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 benefit or applications for insurance that I may have with SISIP Financial;
- administering the policy under which this claim has been made;
- medical case study or review.

I therefore authorize Manulife, SISIP Financial and any of the following persons , institutions and organizations, to provide to and exchange with each other, any of the Personal Information which they have in their possession or control:

- physician, health care practitioner, hospital, clinic, pharmacy or other medical facility or provider of health care or treatment:
- provincial health insurance plan, insurance company, reinsurer;
- insurance broker or benefit plan administrator, employer or former employer and any of their agents performing services relating to any employee benefit;
- federal or provincial government agency, department or organization;
- investigative or security agency, personal information agent or any other person, agency or institution having the Personal Information.

I understand that any Personal Information that is provided, 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 sensitive medical information from someone other than the patient's physician, Manulife and/or SISIP Financial will only release such information through the 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.

| Signature of Certificate Holder | Day Month Year | Signature of Patient or Parent/Guardian (if under 18 yrs old) | Day Month Year |
|---|---|---|---|

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# Advanced Benefit
# Part II - Attending Physician's Statement
Group Policy # 901102

Manulife

## PATIENT AUTHORIZATION

| Surname | First name | Initials | Service Number (SN) of Certificate Holder |
|---|---|---|---|
| | | | |

**Declaration and Authorization by Patient**

I hereby authorize the release to Manulife and SISIP Financial of any information in respect of this claim.
The information provided on this form is protected from unauthorized disclosure under *Canada's Privacy Act* and *Personal Information Protection and Electronics Document Act* and is available to you upon request.

_____ _____

Patient's Signature or Parent/Guardian (if under 18 yrs old) Day Month Year

## PART II: ATTENDING PHYSICIAN'S STATEMENT

Instructions
1) Please print.
2) Return completed form and attachments to your patient or directly to Manulife, SISIP Services Dept., PO Box 1030, 2727 Joseph Howe Drive, Halifax NS B3J 2X5.
3) **Any charge for completing this form is your patient's responsibility.**

## 1. HISTORY

a. Date symptoms first appeared or accident happened.
_____
Day Month Year

b. Date patient ceased work because of current condition.
_____
Day Month Year

c. Has patient ever had same or similar condition? ❑ No ❑ Unknown ❑ Yes, state and describe.

_____

_____

d. Is condition considered chronic? ❑ No ❑ Yes

e. Name(s) and address(es) of other treating physician(s).

_____

_____

## 2. DIAGNOSIS (including any complications) Please include any consultative reports

a. Primary

_____

_____

b. Additional conditions or complications

_____

_____

c. Subjective symptoms

_____

_____

d. Objective signs (including results of current X-rays, EKG's or laboratory data and any relevant clinical findings)

_____

_____

Service Number (SN) of Certificate Holder:

## PART II: ATTENDING PHYSICIAN'S STATEMENT (continued)

### 3. TREATMENT

a. Date of first visit _____ Day Month Year

b. Date of latest visit _____ Day Month Year

c. Frequency of visits ❑ Weekly ❑ Monthly ❑ Other (specify)

_____

_____

d. Nature of treatment (including surgery, physiotherapy and medications prescribed, if any)

_____

_____

### 4. PROGRESS

a. Has patient ❑ Recovered ❑ Improved ❑ Not Improved ❑ Retrogressed

b. Life Expectancy: Is death expected or likely to occur within the next 12 month period?

_____

### 5. ATTENDING PHYSICIAN'S SIGNATURE BLOCK

Remarks:

_____

_____

_____

| Attending Physician's name (please print or attach business card) | Telephone No. of Attending Physician |
|---|---|
| | |

Address of Attending Physician

_____ _____

Attending Physician's signature Day Month Year

FINANCIÈRE SISIP FINANCIAL
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# Advanced Benefit
## Part III-A - Insured Member Agreement
Group Policy # 901102

Manulife

## BACKGROUND INFORMATION

Name of Group Life Insured ("Applicant"): _____

Service/Certificate Number: _____

Amount of Advanced Benefit Requested*: _____

* May apply for 50% of the insured coverage to a maximum of $50,000

## AGREEMENT

1. I hereby request that The Manufacturers Life Insurance Company ("Manulife") issue an Advanced Benefit to me from the group life insurance policy issued to me under Group Policy Number 901102, Certificate Number _____ (" My Policy").
2. I understand that the Advanced Benefit in the amount of $ _____ will be issued to me as a loan against the proceeds eventually payable to my beneficiary(ies) under My Policy, and as such shall constitute a debt owing by me to Manulife.
3. I understand and agree that the amount of any proceeds from My Policy, payable to my beneficiary(ies) at the date of my death will be reduced by the amount of the Advanced Benefit paid to me.
4. In exchange for the payment of the Advanced Benefit to me, I acknowledge and agree that Manulife shall have a first claim against the proceeds under My Policy, in priority to any other claimant(s) for the proceeds, including but not limited to my beneficiary(ies), to the extent of the value of the Advanced Benefit, as at the date of my death. In the event that the proceeds are insufficient to repay the Advanced Benefit to Manulife, I understand that Manulife has the right to claim the amount of the Advanced Benefit from my estate.
5. I agree to keep the coverage under My Policy in force, to the earlier of the date of my death or my attaining age 75, in an amount that is sufficient to repay to Manulife, upon my death, the amount of the Advanced Benefit.
6. I agree and acknowledge that since the payment of this Advanced Benefit to me will reduce the amount payable to my beneficiary(ies), I am responsible for informing my beneficiary(ies) of the reduction in the proceeds under My Policy and agree, on my own behalf, and on behalf of my heirs, successors and assigns, to hold harmless and keep indemnified Manulife from any losses, causes, claims, demands or actions which may arise from or as a result of this payment.

## SIGNATURE:

Dated this _____ day of _____, 20_____.

_____

Applicant's Name (Printed)

_____

Applicant's Signature

**THE FOLLOWING CONSENT MUST BE SIGNED IF YOU HAVE NAMED AN IRREVOCABLE BENEFICIARY ON YOUR POLICY:**

## IRREVOCABLE BENEFICIARY CONSENT

I have been named as an irrevocable beneficiary of the life insurance policy referred to in this Agreement. I have read this Agreement and understand that the amount of life insurance proceeds available to me will be reduced by the Advanced Benefit payment made to the Applicant, pursuant to the terms and conditions of this Agreement. I hereby provide my irrevocable consent for Manulife to make the Advanced Benefit payment to the Applicant, in accordance with the terms and conditions herein, and hereby forever release and hold Manulife harmless for the amount of such Advanced Benefit Payment.

Dated this _____ day of _____, 20_____.

_____

Irrevocable Beneficiary Name (Printed)

_____

Irrevocable Beneficiary Signature

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# Advanced Benefit
# Part III-B - Insured Spouse Agreement
Group Policy # 901102

Manulife

## BACKGROUND INFORMATION

Name of Group Life Insured ("Applicant"): _____

Service/Certificate Number: _____

Name of Spouse: _____

Amount of Advanced Benefit Requested*: _____

* May apply for 50% of the insured coverage to a maximum of $50,000

## AGREEMENT

1. I hereby request that The Manufacturers Life Insurance Company ("Manulife") issue an Advanced Benefit to me from the group life insurance policy issued to me, on the life of my spouse, under Group Policy Number 901102, Certificate Number _____(" My Policy").
2. I understand that the Advanced Benefit in the amount of $_____will be issued to me as a loan against the proceeds eventually payable to the beneficiary(ies) under My Policy, and as such shall constitute a debt owing by me to Manulife.
3. I understand that the amount of any proceeds from My Policy, payable to the beneficiary(ies) at the date of my spouse's death will be reduced by the amount of the Advanced Benefit paid to me.
4. In exchange for the payment of the Advanced Benefit to me, I acknowledge and agree that Manulife shall have a first claim against the Proceeds under My Policy, in priority to any other claimant(s) for the Proceeds, including but not limited to the beneficiary(ies), to the extent of the value of the Advanced Benefit, as at the date of my spouse's death. In the event that the proceeds are insufficient to repay the Advanced Benefit to Manulife, I understand that Manulife has the right to claim the amount of the Advanced Benefit from me or my estate.
5. I agree to keep the coverage under My Policy in force, to the earlier of the date of my spouse's death or my spouse attaining age 75, in an amount that is sufficient to repay to Manulife, upon my spouse's death, the amount of the Advanced Benefit.
6. I agree and acknowledge that since the payment of this Advanced Benefit to me will reduce the amount payable to the beneficiary(ies), I am responsible for informing the beneficiary(ies) of the reduction in the proceeds under My Policy and agree, on my own behalf, and on behalf of my heirs, successors and assigns, to hold harmless and keep indemnified Manulife from any losses, causes, claims, demands or actions which may arise from or as a result of this payment.

## SIGNATURE:

Dated this _____ day of _____, 20_____.

_____

Applicant's Name (Printed)

_____

Applicant's Signature

**THE FOLLOWING CONSENT MUST BE SIGNED IF YOU HAVE NAMED AN IRREVOCABLE BENEFICIARY ON YOUR POLICY:**

## IRREVOCABLE BENEFICIARY CONSENT

I have been named as an irrevocable beneficiary of the life insurance policy referred to in this Agreement. I have read this Agreement and understand that the amount of life insurance proceeds available to me will be reduced by the Advanced Benefit payment made to the Applicant, pursuant to the terms and conditions of this Agreement. I hereby provide my irrevocable consent for Manulife to make the Advanced Benefit payment to the Applicant, in accordance with the terms and conditions herein, and hereby forever release and hold Manulife harmless for the amount of such Advanced Benefit Payment.

Dated this _____ day of _____, 20_____.

_____

Irrevocable Beneficiary Name (Printed)

_____

Irrevocable Beneficiary Signature

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# Advanced Benefit
# Part III-C - Insured Dependent Agreement
Group Policy # 901102

Manulife

## BACKGROUND INFORMATION

Name of Group Life Insured ("Applicant"): _____

Service/Certificate Number: _____

Name of Dependent: _____

Amount of Advanced Benefit Requested*: _____

* May apply for a maximum of 50% of the insured coverage.

## AGREEMENT

1. I hereby request that The Manufacturers Life Insurance Company ("Manulife") issue an Advanced Benefit to me from the group life insurance policy issued to me, on the life of my dependent (named above), under Group Policy Number 901102, Certificate Number _____(" My Policy").
2. I understand that the Advanced Benefit in the amount of $_____will be issued to me as a loan against the proceeds eventually payable to me or my estate under My Policy, and as such shall constitute a debt owing by me to Manulife.
3. I understand that the amount of any proceeds from My Policy, payable to me or my estate at the date of my dependent's death will be reduced by the amount of the Advanced Benefit paid to me.
4. In exchange for the payment of the Advanced Benefit to me, I acknowledge and agree that Manulife shall have a first claim against the Proceeds under My Policy, in priority to any other claimant(s) for the Proceeds, including but not limited to me or my estate, to the extent of the value of the Advanced Benefit, as at the date of my dependent's death. In the event that the proceeds are insufficient to repay the Advanced Benefit to Manulife, I understand that Manulife has the right to claim the amount of the Advanced Benefit from me or my estate.
5. I agree to keep Member and/or Spousal coverage under My Policy in force, to the earlier of the date of my dependent's death or the date my dependent ceases to be eligible for coverage under My Policy, so that I may repay Manulife, upon my dependent's death, the amount of the Advanced Benefit.
6. I agree and acknowledge that since the payment of this Advanced Benefit to me will reduce the amount payable to the beneficiary(ies), I am responsible for informing the beneficiary(ies) of the reduction in the proceeds under My Policy and agree, on my own behalf, and on behalf of my heirs, successors and assigns, to hold harmless and keep indemnified Manulife from any losses, causes, claims, demands or actions which may arise from or as a result of this payment.

## SIGNATURE:

Dated this _____ day of _____, 20_____.

_____

Applicant's Name (Printed)

_____

Applicant's Signature