Manulife Financial

Weekly Indemnity Claim Form

MEMBER'S STATEMENT

1. Member's Name

2. Date of birth ____ Day ____ Month ____ Year

3. Sex ☐ Male ☐ Female

4. a) Address

b) Home Phone Number

5. Social Insurance No.

6. Name of attending Doctor (Please print)

7. Date Total Disability commenced ____ Day ____ Month ____ Year

8. Date of expected return to work ____ Day ____ Month ____ Year

9. If disability due to an accident, please indicate: a) Date and time of accident ____ Day ____ Month ____ Year at ____ A.M. ☐ P.M. ☐

b) Did accident occur at work? Yes ☐ No ☐ c) Brief description of accident. ____

10. a) If confined to hospital: Name of hospital?

Date and time admitted ____ Day ____ Month ____ Year at ____ A.M. ☐ P.M. ☐

Date and time discharged ____ Day ____ Month ____ Year at ____ A.M. ☐ P.M. ☐

b) If examined and/or treated at emergency department but not confined to hospital: Name of Hospital?

Date and time seen ____ Day ____ Month ____ Year at ____ A.M. ☐ P.M. ☐

I/We certify that the statements provided by me are true and accurate to the best of my knowledge and belief.

I/We understand that Manulife Financial may investigate or review this claim. I/We authorize any physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medical or medically-related facility, insurance company, Workers' Compensation Board, group plan administrator, employer, policyholder or any other corporation, organization, institution, association or person to release and exchange any medical or benefit payment information or any other records requested by Manulife Financial to establish or review the validity of this claim.

I/We understand that this information will be maintained in a GROUP LIFE, HEALTH, and DISABILITY file with Manulife Financial. I understand that persons, with satisfactory identification and proof of entitlement, will have the right to request access and, if necessary, rectify such personal information.

I/We authorize the use of my/our Social Insurance Number for the purpose of tax reporting and for the identification and administration of the Group Benefits.

I/We agree that a photocopy of this authorization shall be as valid as the original.

Signed this ____ day of ____ , ____ . X ____

Signature of Member

CONTRACTHOLDER'S STATEMENT

1. Contractholder MOLSON COORS CANADA Class Code Group No. 85020 Division No.

2. Member's Name Social Insurance No. Certificate No.

3. Effective date of W.I. coverage ____ Day ____ Month ____ Year

4. If cancelled, please indicate: a) Date: ____ Day ____ Month ____ Year

b) Reason:

5. Date last worked ____ Day ____ Month ____ Year

a) Hours scheduled: from ____ ☐ a.m. ☐ p.m. to ____ ☐ a.m. ☐ p.m.

b) Hours worked: from ____ ☐ a.m. ☐ p.m. to ____ ☐ a.m. ☐ p.m.

Date returned to work ____ Day ____ Month ____ Year at ____ ☐ a.m. ☐ p.m.

6. Rate of Weekly Benefit this member is entitled to receive $ ____

7. Is claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No

8. What was member's Work Status at onset of disability?

a) Working full time ☐

b) Laid off ☐

c) On leave of absence ☐

d) On paid vacation ☐

If (b), (c) or (d): From what date ____ to what date ____

9. Brief description of job duties ____

10. Have you any reason to question the validity of this claim or other information helpful to its processing?

11. If applicable for tax purposes, please indicate a) Province in which member is taxed ____

b) Federal net claim amount $ ____ c) Amount of Provincial exemption $ ____

NOTICE: By completing this employer's statement, information contained herein will become part of a GROUP LIFE, HEALTH and DISABILITY file with Manulife Financial and might be accessible by the employee or third parties to whom access has been granted or those authorized by law. By signing the statement, you consent to such unedited release of any information contained herein. An unsigned statement has no validity and cannot be considered for evaluation of any claim.

Authorized Signature	Date	Day	Month	Year

SD - 5 Loss of time benefit

ATTENDING PHYSICIAN'S STATEMENT

Instructions
1. *Please print.*
2. *Part 1 to be completed by patient.*
3. *Part 2 to be completed by physician.*
4. *Any charge for completing this form is the patient's responsibility.*

Part 1: Patient Authorization

Policy No. 85020

Name

Date of birth *(day, month, year)*

I hereby authorize the release to my insurer and my policyholder of any information in respect of this claim.
Patient's Signature
X

Date

Part 2. Attending Physician's Statement

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened *(day, month, year)*

   b) has patient had same or similar condition
   ☐ No ☐ Yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment
   ☐ Yes ☐ No ☐ Unknown

4. If patient is/was pregnant indicate date or expected dated of confinement *(day, month, year)*

5. Date of hospital in-patient admission *(day, month, year)*

   Date of discharge *(day, month, year)*

6. Nature of treatment *(e.g. date and type of surgery)*

7. a) If patient was referred to you, give name of referring physician

   b) If you have referred patient to a specialist, give name(s) of physicians

8. a) Date of first visit during present period of absence from work *(day, month, year)*

   b) Date of latest attendance *(day, month, year)*

   c) Were you actively supervising this patient's care during the full period
   ☐ No, comments in remarks ☐ Yes, state frequency of visits ☐ Weekly ☐ Monthly ☐ Other *(specify)*

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
   From *(day, month, year)* To *(day, month, year)* inclusive

   b) If still unable to work, give approximate date patient should be able to return *(day, month, year)*
   or
   the estimated number of weeks before possible return

10. Please advise how present condition affects patient's ability to work *(for example restrictions, limitations, proposed surgery, etc.)*

11. Remarks - Please provide comments and further details which you feel would be helpful

Name of attending physician *(please print)*

Specialty

Telephone No.
( ) -

Address *(number, street, city, province, postal code)*

NOTICE: By completing this physician's statement, information contained herein will become part of a GROUP LIFE, HEALTH and DISABILITY file with Manulife Financial and might be accessible by the patient through a designated health care professional of their choice, Manulife employees, or third parties as permitted by law. By providing the information herein, you consent to such unedited release of any information contained herein.

Signature

Date *(day, month, year)*