

### Disability claims department

In order to ensure confidentiality of personal information, Manulife will establish a disability claim file in which information concerning all of your disability claims will be kept.

Only employees or authorized agents of Manulife responsible for the management of your claim shall have access to the file.

Tel: 1-877-481-9169 Fax: 1-866-292-9050

#### MONTREAL

Manulife Group Benefits  
 Attention: Disability Claims  
 P.O. Box 400 STN Place-D'Armes  
 Montreal QC H2Y 3H1

#### TORONTO

Manulife Group Benefits  
 Attention: Disability Claims  
 P.O. Box 4105 STN A  
 Toronto ON M5W 2P4

#### CALGARY

Manulife Group Benefits  
 Attention: Disability Claims  
 P.O. Box 1315 STN M  
 Calgary AB T2P 2L2

### Instructions for the member

Please complete the "Member statement" section.

Please ensure that the Plan Sponsor completes the "Plan Sponsor statement" section.

Please ensure that your physician completes the "Attending physician statement – Psychological conditions" if the primary reason for your absence from work is psychological or the "Attending physician statement – Physical conditions" for all other conditions. As well, please provide your physician with a copy of your completed Member statement so that the physician will have your signed authorization to release information to Manulife.

Please note that any costs incurred in the completion of the "Attending physician statement" are your responsibility.

Please ensure that all of the above-mentioned forms are submitted to Manulife on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.

Please complete the direct deposit authorization at the bottom of this page if you are not already using direct deposit with Manulife. The form should then be submitted with your claim in order to have your benefits deposited directly into your bank account, should your claim be approved.

### Instructions for the Plan Sponsor

Please complete the "Plan Sponsor statement" section.

### Instructions for the physician

Please complete the appropriate "Initial Attending Physician's statement", depending on the nature of the primary diagnosis.

### DIRECT DEPOSIT AUTHORIZATION\*

Plan contract and member numbers			
Plan Member Name		Social Insurance Number	
Address (number, street, apt.)	City	Province	Postal code
Name of financial institution			
Address (number, street, apt.)	City	Province	Postal code
Type of account	<input type="checkbox"/> Savings	<input type="checkbox"/> Personal chequing	<input type="checkbox"/> Current
Transit number		Bank account number	
<p>I hereby authorize the Manulife to deposit, until further notice, payments due to me from the above policy, into my bank account. I agree that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, I authorize the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my certificate number. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.</p>			
Plan Member's signature		Date <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	

\* Please complete this section or attach a personalized void cheque to ensure that we obtain your accurate banking information.

## MEMBER STATEMENT

Please note that all questions must be answered in as much detail as possible.

### General information

Plan member contract n°	<input type="text"/>	Plan member certificate n°	<input type="text"/>
Title (Mr./Mrs./Ms.)	Surname	Given name(s)	Initial
Address (n°, street)		City	Province
Postal code	Telephone n°	Email	
Name of employer (and division if different)		Occupation (just prior to last day worked)	

SIN	<input type="text"/>	Date of birth	<input type="text"/>
Language :	<input type="checkbox"/> English <input type="checkbox"/> French	Gender:	<input type="checkbox"/> M <input type="checkbox"/> F
		Original date of hire	<input type="text"/>

Tax exempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state reason.
Other current employer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please name

### Claim information

Was the reason you stopped working due to:

Illness  Injury away from work  Motor vehicle accident (not while working)<sup>1</sup>  Occupational illness or work accident

If you have suffered an injury, please describe how, when, and where the injury occurred.

<input type="text"/>
<input type="text"/>
<input type="text"/>

What was the last day you worked?  Were you performing:  Your regular duties  Modified duties

Was this a full day?  Yes  No If No, how many hours did you work on your last day?

What was the date you were first unable to work?

When did you first notice these symptoms?

When were you first treated by a physician?

Please describe all of your symptoms, including frequency and severity.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Have you ever had the same or similar illness or injury?  Yes  No

If Yes, please provide the dates and name(s) of physicians who treated you at the time.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Please describe the major duties of your occupation.

<input type="text"/>
<input type="text"/>
<input type="text"/>

**MEMBER STATEMENT (CONTINUED)**

Please describe why you are unable to perform the duties of your occupation.

Do you have an expected date of return to work?  Yes  No If Yes, please provide the date

**Health care professional information**

Please list all of the health care professionals you have consulted in the last 12 months, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name	Specialty	
Complete address	Telephone n°	Fax n°

Consulted from         to

Name	Specialty	
Complete address	Telephone n°	Fax n°

Consulted from         to

Name	Specialty	
Complete address	Telephone n°	Fax n°

Consulted from         to

**Other income information**

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.

Source	Have you applied?		Are you receiving payment?			Monthly amount	Claim no., contact name, telephone no.
	Yes	No	Yes	No	Pending		
Worker's Comp / CSST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Canada Pension Plan – Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Canada Pension Plan – Retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Québec Pension Plan (QPP) – Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Québec Pension Plan (QPP) – Retirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Employment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Auto Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Insurer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

### Member authorization and declaration

I certify that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge. I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I agree to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, and I authorize Manulife to deduct such monies from my group benefits. Manulife will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes.

I authorize any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency, to release my personal information to Manulife and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize Manulife, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize the use of my Social Insurance Number (SIN) for the purposes of tax reporting. I authorize the use of my SIN for the purposes of identification and administration, if my SIN is used as my plan member certificate number.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original. I acknowledge that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits), or from my Plan Sponsor.

I understand that any personal information provided to or collected by Manulife in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

Plan Member's Signature

Date

### Authorization: e-mail consent

By providing my personal e-mail address, I am authorizing Manulife to use the e-mail address provided as an additional means of communication with me about my file. I acknowledge that correspondence by e-mail may contain personal information including, but not limited to, medical, employment and financial information.

I understand that my personal information is being sent in a manner that is not yet guaranteed as a secured means of communication.

Plan Member's Signature

Date

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Attention: Disability Claims  
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Calgary AB T2P 2L2

### PLAN SPONSOR STATEMENT

Please note that all questions must be answered in as much detail as possible.

#### Plan Sponsor information

Name of Plan Sponsor (Employer/Union/Association)  Name of subsidiary or division (if different)

Complete address

#### Member information

Plan contract number  Division n°  Class n°  Plan member certificate n°

Surname  Given name(s)  Initial

Social insurance number  Permanent employee?  Yes  No

Nature of request for benefits:  Short-Term Disability  Long-Term Disability  Waiver of premiums  Dismemberment

Was the employee actively at work when the absence began / loss occurred?  Yes  No

If Yes, please provide the date on which this member was first covered under this plan contract number:

If No, please comment.

What was the member's date of hire?  last date of work?

If already back at work, what was the start date?  Part-time   Full-time

What was the member's main reason for absence:

Illness  Injury away from work  Motor vehicle accident (not while working)  Occupational illness or work accident

Please indicate the hours of work in a normal week, if shift work, please provide work schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

What was the member's gross weekly salary as of his/her last day of work?  Was the member  Salaried  Hourly

#### Tax information

Please complete only if benefit is taxable.

TD1  TP1  Percentage to be deducted  % TD1 TP1 Member's province of residence for income tax purposes

Did the member receive any income during the disability period?  Yes  No

If Yes, please select one of the following:  Vacation  Maternity leave  Employment insurance  Sick days  Statutory holidays  Other

If Other, please comment.

**PLAN SPONSOR STATEMENT (CONTINUED)**

Amount \$  From         to

Has the member submitted a claim to the following government bodies?

- WSIB / WCB / CSST     EI     CPP     QPP (RRQ)     Provincial automobile insurance board

**Occupational information**

What was the member's regular occupation immediately prior to his/her stopping work?

Were the member's duties modified from his/her regular occupation?     Yes     No

Please describe this employee's regular occupation (or attach a copy of the company's job description) as well as any modifications, if any.

The following physical demands analysis of the member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

1. at any one time without a break (approximately) **and**;
2. in total throughout the day (approximately)

Physical demands analysis		1.	2.
Sitting			
Standing			
Driving			
Climbing up and down the stairs			
Lifting	<input type="checkbox"/> 0 - 10 pounds	<input type="checkbox"/> 10 - 20 pounds	
with lifting device?	<input type="checkbox"/> 20 - 50 pounds	<input type="checkbox"/> 50 pounds +	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pushing/Pulling	<input type="checkbox"/> 0 - 10 pounds	<input type="checkbox"/> 10 - 20 pounds	
	<input type="checkbox"/> 20 - 50 pounds	<input type="checkbox"/> 50 pounds +	

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.)

Does the participant wear personal protective equipment (i.e. safety glasses/footwear, respiratory protection, ear protection, etc.)?     Yes     No

If Yes, please describe.

**Declaration**

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ Date

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

### Disability claims department

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 Calgary AB T2P 2L2

### INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS)

#### Patient authorization

Name (last, first, initial) Plan contract number Plan member certificate number

Height Weight Date of birth D D M M Y Y Y Y

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of the form.**"

Patient's signature Date D D M M Y Y Y Y

#### Diagnosis

What is the primary diagnosis?  
 \_\_\_\_\_  
 \_\_\_\_\_

When did the symptoms first appear or date accident occurred? D D M M Y Y Y Y

What was the date of the patient's first visit for his/her current condition? D D M M Y Y Y Y

What was the date of the patient's first visit during the present period of absence from work? D D M M Y Y Y Y

If the patient has a cardiac condition, what is his/her current functional capacity based on the American Heart Association classifications:

- Yes Class 1 (No Limitation)     Class 2 (Slight Limitation)     Class 3 (Marked Limitation)     Class 4 (Severe Limitation)

What is the patient's blood pressure? Current Previous Date D D M M Y Y Y Y

If your patient has a back/spinal condition, have an X-ray, MRI, or any other tests been performed?  Yes  No

If Yes, please attach a copy of the results of the X-rays, MRIs, or any other tests which may have been performed.

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work?  Yes  No

If Yes, please elaborate.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide a complete list of the patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)**

What are the patient's current limitations **(things that he/she cannot do)**? Please be specific.

What are the patient's current restrictions **(things that he/she should not do)**? Please be specific.

Is your patient competent to manage his/her own financial affairs?

Yes

No

Please indicate the date the patient stopped working based on your recommendation.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

If a potential return to work date has been discussed, please provide the date.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Has the patient ever had the same or similar condition?

Yes

No

If Yes, please provide dates and describe.

Is the patient's condition due to injury or sickness arising out of his/her employment?

Yes

No

If Yes, please elaborate.

If the patient was/is pregnant, please indicate the date or expected date of confinement.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**Treatment**

Frequency of patient visits:

Weekly

Bi-weekly

Monthly

Other

If Other, please describe.

Please detail the patient's past and present treatment (e.g. date and type of surgery) as well as response to treatment.

Has the patient been hospitalized?

Yes

No

If Yes, please provide the name of the hospital(s) and the dates of confinement.



**INITIAL ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL CONDITIONS) (CONTINUED)**

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed							
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y

If this patient was referred to you, please provide the name of the referring physician.


If you have referred the patient to a specialist(s), please provide the name(s) of the specialist(s) and area of specialty.


Name (please print)	Specialty
Complete address	
Telephone n°	Fax n°

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Signature	Date	D	D	M	M	Y	Y	Y	Y
-----------	------	---	---	---	---	---	---	---	---



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 Calgary AB T2P 2L2

### INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS)

#### Patient authorization

Name (last, first, initial) Plan contract number Plan member certificate number

Height Weight Date of birth D D M M Y Y Y Y

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of the form.**"

Patient's signature Date D D M M Y Y Y Y

#### Diagnosis

Please indicate the diagnosis using DSM – IV Multi axial evaluation nomenclature and code numbers.

I
II
III
IV
V

Is there a secondary diagnosis or additional complication which might affect the duration of absence from work?  Yes  No

If Yes, please elaborate.

Please provide a complete list of your patient's symptoms (including severity and frequency), identifying which of the symptoms listed you have objectively observed.

When did symptoms first appear? Date D D M M Y Y Y Y

Please describe the patient's initial reason for seeking treatment.

**INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)**

Was there a precipitating event?

Yes

No

If Yes, please elaborate.

What was the date of the patient's first visit for his/her current condition?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

What was the date of the patient's first visit during the present period of absence from work?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Is your patient's condition caused directly or indirectly by his/her employment?

Yes

No

If Yes, please elaborate.

What are the patient's current limitations (things that he/she **cannot** do)? Please be specific.

What are the patient's current restrictions (things that he/she **should** not do)? Please be specific.

Is your patient competent to manage his/her own financial affairs?

Yes

No

Please indicate the date the patient stopped working based on your recommendation.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

If a potential return to work date has been discussed, please provide the date.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**Treatment**

Frequency of patient visits:

Weekly

Bi-weekly

Monthly

Other

If Other, please describe.

Please detail the patient's past and present treatment (including psychotherapy) response to treatment, and compliance.

Has the patient been hospitalized?

Yes

No

If Yes, please provide the name of the hospital(s) and the dates of confinement.

**INITIAL ATTENDING PHYSICIAN'S STATEMENT (PSYCHOLOGICAL CONDITIONS) (CONTINUED)**

Please list all of the medications that the patient is currently taking, including dosage and date prescribed.

Medication	Dosage	Date prescribed							
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y

**Functional capacities evaluation**

Please provide your opinion as to the extent of the patient's impairment in performing the following on a sustained basis:

**None:** No impairment in this area after basis.

**Mild:** Suspected impairment of slight importance which does not affect functional ability.

**Moderate:** Impairment affects but does not preclude ability to function.

**Moderately Severe:** Impairment significantly affects ability to function.

**Severe:** Extreme impairment of ability to function.

	None	Mild	Moderate	Moderately severe	Severe
Ability to relate to friends and family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to attend to personal care (bathing, cooking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to carry out household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to relate to co-workers and supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform work where contact with others will be minimal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand, carry out, and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform tasks involving minimal intellectual effort or repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to follow a regular work schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make independent judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform intellectually complex tasks requiring higher levels of reasoning, math, and language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supervise or manage others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name (please print) \_\_\_\_\_ Specialty \_\_\_\_\_

Complete address \_\_\_\_\_

Telephone n° \_\_\_\_\_ Fax n° \_\_\_\_\_

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Signature \_\_\_\_\_ Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---