Manulife

Plan Sponsor Statement – Condensed

Life Waiver of Premium

An incomplete form may result in delays in the adjudication of your life waiver of premium claim.

Please see page 2 for instructions.

To be completed by the plan sponsor. Please print clearly, answer all questions, and sign and date this form. Return the completed form along with the supporting documentation listed in the checklist at the bottom of this page.

Plan sponsor instructions

Submit the Waiver of Premium form on the earlier of the date a decision has been rendered about the plan member's Long Term Disability (LTD) claim or the end of the Life Waiver qualifying period.

Ask the plan member to sign the plan member authorization. Provide Manulife with the signed authorization.

Include a copy of the plan member's Long Term Disability decision letter (approval or decline). Please provide us with a copy of any subsequent letters from your LTD carrier about the status of the LTD claim. Any change in status of the LTD claim (initial approval, termination, suspension, approval beyond definition change) may directly impact the status of the Life Premium Waiver.

The Life Waiver of Premium eligibility process

In assessing eligibility for Life Waiver of Premium, we determine if the plan member meets all eligibility criteria. With the simplified submission process we mirror your LTD carrier's decision about proof of disability but we make all other determinations about contractual eligibility.

Submission checklist

- ◯ Plan sponsor statement
- ◯ Plan member authorization
- ◯ Copy of LTD carrier's decision letter
- ◯ Copy of enrolment card for self administered groups

Please send the completed form to:

Manulife Group Benefits
Wellness, Disability & Life
PO BOX 800 STN Waterloo
WATERLOO ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

Manulife

Group Benefits
Plan Sponsor Statement – Condensed
Life Waiver of Premium

1 Plan sponsor information

Plan contract number	Name		
Address		Province	Postal code
Contact	Title	Phone number	Fax number

2 Plan member identification

Name (last, first, initial)			Sex ◯ Male ◯ Female
Plan member certificate number	Class	Division number	Date of hire (dd/mmm/yyyy)

3 Life coverage

Please provide copy of enrolment card on self administered groups.

◯ **Group Life Benefit**

Effective date of coverage (dd/mmm/yyyy)

◯ Basic	$ _____	◯ Spousal	$ _____
◯ Optional	$ _____	◯ Optional spousal	$ _____
◯ Dependent children	$ _____		

◯ **Group Accidental Death and Dismemberment (AD&D) benefit**

Effective date of coverage (dd/mmm/yyyy)

◯ Basic	$ _____	◯ Spousal	$ _____
◯ Optional	$ _____	◯ Optional spousal	$ _____

4 Life Waiver coverage information

a) What was the date last worked?

(dd/mmm/yyyy)

b) Has life coverage been terminated?

◯ Yes ◯ No If *yes,* please provide the following information.

Date coverage terminated (dd/mmm/yyyy)

Reason why life coverage terminated

5 Plan member earnings and benefit information

Please provide the following information, **OR** a copy of the current payslip.

a) What was the base salary/wage when plan member was last at work?

Base salary/wage

$

Payment schedule

◯ Hourly ◯ Weekly ◯ Bi-weekly
◯ Semi-monthly ◯ Monthly ◯ Annual

b) Commissions? ◯ Yes ◯ No

If *yes,* please provide the following information.

Commissions (Please provide T4A documentation as per policy provisions.)

$

c) What is the date of the last salary increase?

(dd/mmm/yyyy)

6 Declaration

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

Plan administrator signature

Plan administrator phone number

Date (dd/mmm/yyyy)

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.

7 Plan member authorization

Life Waiver of Premium

Plan contract number

Plan member certificate number

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 or 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 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, 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.

Print

Plan member signature

Date (dd/mmm/yyyy)