Manulife

Application for Compassionate Assistance Loan

ELIGIBILITY: employee must be terminally ill with a life expectancy of 24 months or less and must be approved for waiver of premium. Eligibility for this loan is subject to Manulife's Terms and Conditions.

1 Policy information

Plan/Group number	Division number	Certificate number
133390		

Plan sponsor's name

Plan sponsor's address (number, street, suite)

City or town	Province	Postal code

Employee name	Date of birth (dd/mmm/yyyy)

Employee's address (number, street, apartment)

City or town	Province	Postal code

2 Medical information

Name of attending physician	Telephone number
	( )

Physician's address (number, street, suite)

City or town	Province	Postal code

Current diagnosis

3 Loan information

Amount of basic life insurance

Amount of loan requested

(Maximum loan is the lesser of 50% of the plan member's basic life insurance or maximum of $50,000.00)

Original to Manulife. If required, retain a photocopy for your files.

Please complete next page.

4 Certification and authorization

I certify that the information in this form is true and complete, to the best of my knowledge. **I also certify** that any further verbal or written statement provided by me will be true and complete to the best of my ability.
I understand that Manulife will investigate this claim. **I authorize** any person or organization who has information pertaining to this claim, including any employer, group plan administrator, health care professional, health care institution 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 and exchange information requested by Manulife and/or its claims service providers for the purpose of administering the group plan and assessing my claim.
I authorize Manulife, its reinsurers and its claims service providers to collect, to use and to exchange with the persons or organizations listed above and/or each other any information needed for the purpose of plan administration, claim assessment, audit, investigation and management of my claim.
I authorize the use of my Social Insurance Number for the purpose of tax reporting and if my social insurance number is used as my certificate number, **I authorize** its use for the identification and administration of my group benefits.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original.
I understand that information relating to Manulife's privacy policies is available upon written request, on Manulife's website, www.manulife.ca, or through my Plan Sponsor.

Plan member's signature or appointed representative	Date signed (dd/mmm/yyyy)

At Manulife, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, if necessary, correct any inaccurate information.

5 Mailing instructions

Please submit this form to the appropriate address:

For English Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: group_disability_claims@manulife.ca

For French Claims
Manulife
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-877-481-9169
Fax: 1-866-292-9050
Email: groupe_invalidite@manuvie.ca

If sending by courier
Manulife
Attn: Group Life Claims
2000 Mansfield, Suite 220
Montreal QC H3A 2Y8

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