Manulife Financial

For your future™

Plan Sponsor Statement

Waiver of Premium Claim for

- **Basic & Optional Life Benefit**
- **AD&D Benefit**
- **Survivor Benefit**
- **Critical Illness**

An incomplete form may result in delays in the adjudication of the plan member's waiver of premium claim.

See page 2 for instructions.

Disability management

The most important thing you can do to facilitate your plan member's safe and timely return to work is to maintain continuous contact with the plan member from the time he/she leaves the workplace.

Be sure to let the plan member know if your company is able to provide transitional work duties and who the plan member can talk to, confidentially, about his or her specific accommodation needs.

Plan administrator instructions

- **Please print clearly; answer all applicable questions; sign and date the form.**
- Ensure the work information section on page 7 is completed and signed by **plan member's supervisor**.
- Submit this waiver of premium form to the address below as soon as it is known that the plan member is not expected to return to work before the qualifying period has expired, even if the plan member has applied, or been accepted for any type of workers' compensation benefits.
- Help the plan member understand the nature of the waiver of premium coverage, what information is required and what costs, if any, are the plan member's responsibility.
- Advise plan member to submit forms to you **OR** Manulife Financial as soon as it is known that the plan member is not expected to return to work and no later than 6 weeks before the qualifying period expires the qualifying period expires.
- **Note: If we have managed the plan member's short term disability absence, please ignore the following instructions regarding the Attending Physician's Statement as we will already have their medical information on file**.
- Provide the plan member with a Member Statement form and an Attending Physician's Statement form for the family physician or attending specialist. Ask the plan member to complete the patient authorization section at the top of page 3 of the Attending Physician's Statement form before they take it to their physician.
- Remind the plan member to have their physician attach consultation, progress and test result reports to APS form (Attending Physician's Statement).

The Waiver of Premium eligibility process

In assessing eligibility for Waiver of Premium, we gather information from you, the plan member and the plan member's physician(s) to compare restrictions and limitations with job demands.

All of the above information will be reviewed to determine whether the plan member meets the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Please send the completed form to:

If you live outside Quebec:

Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 1030
HALIFAX NS B3J 2X5
Tel: 1-800-565-0627
(902) 453-4300
Fax: 1-866-292-9050
(902) 429-7292

If you live in Quebec:

Manulife Financial Group Benefits
Attention: Disability Claims
PO BOX 395 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-866-236-6313
(514) 288-6268
Fax: 1-888-488-6738
(514) 286-6738

Manulife Financial

For your future™

Group Benefits
Plan Sponsor Statement
Waiver of Premium

1 Plan sponsor information

Name

Address (number, street, suite) | Province | Postal code

Contact | Title | Phone number ( ) Ext. | Fax number ( )

2 Plan member identification

Name (last, first, initial) | ◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.

Plan member certificate number | Class | Division number | Date of birth (dd/mmm/yyyy)

3 Benefits

For plan sponsor administered groups only.
*Please submit **ORIGINAL** enrolment form for each applicable benefit.*

◯ **GROUP LIFE BENEFIT**

Plan contract number | Division number | Effective date of coverage (dd/mmm/yyyy)

Amount of life coverage when last actively at work

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

◯ **GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT**

Plan contract number | Division number | Effective date of coverage (dd/mmm/yyyy)

Amount of AD&D coverage when last actively at work

◯ Basic $ | ◯ Spousal $ | ◯ Optional $ | ◯ Optional spousal $

◯ **GROUP SURVIVOR BENEFIT**

Plan contract number | Division number | Effective date of coverage (dd/mmm/yyyy)

Monthly survivor benefit amount $ | Type of coverage ◯ Spousal ◯ Spousal and children ◯ Other (specify)

◯ **GROUP CRITICAL ILLNESS**

Plan contract number | Division number | Effective date of coverage (dd/mmm/yyyy)

Amount of critical illness coverage

◯ Basic $ | ◯ Spousal $ | ◯ Optional $ | ◯ Child $

4 Waiver coverage information

a) What was the date of hire?

(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

c) Has critical illness coverage been terminated?

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

Date coverage terminated (dd/mmm/yyyy) | Reason why critical illness coverage terminated

4 Waiver coverage information (continued)

d) What were the plan member's work hours?

◯ Full-time HRS/WK _____ | ◯ Part-time HRS/WK _____ | ◯ Other HRS/WK _____

e) What was the employment status prior to the disability date?

◯ Actively employed **OR** ◯ Leave of absence ◯ Disability leave ◯ On layoff ◯ Pensioned ◯ Terminated

Please provide effective date (dd/mmm/yyyy)

f) What is the plan member's normal retirement date?

(dd/mmm/yyyy)

5 Work schedule information

a) What was the date last worked and the next scheduled work date?

Date last worked (dd/mmm/yyyy) | Next scheduled work date (dd/mmm/yyyy)

b) List any dates plan member worked during the qualifying period.

(dd/mmm/yyyy)

c) What is the return to work date?

Return to work date (dd/mmm/yyyy) | ◯ Actual ◯ Expected ◯ Unknown

6 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 ◯ Annually

b) Commissions? ◯ Yes ◯ No
If yes, please provide the following information.

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

Payment schedule: ◯ Hourly ◯ Weekly ◯ Bi-weekly ◯ Semi-monthly ◯ Monthly ◯ Annually

c) Other income? (if applicable)

Other income (overtime, bonus, shift differential as per policy provisions)
$

Payment schedule: ◯ Hourly ◯ Weekly ◯ Bi-weekly ◯ Semi-monthly ◯ Monthly ◯ Annually

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

Date of last salary increase (dd/mmm/yyyy)

7 Additional earnings

Please indicate if any of the following have been paid (or are payable) since date plan member last worked.

	PAID/PAYABLE	PERIOD	
Salary continuance	◯ Yes ◯ No	To	From
Sick leave	◯ Yes ◯ No	To	From
Vacation pay	◯ Yes ◯ No	To	From
Short term disability	◯ Yes ◯ No	To	From
Retirement pension	◯ Yes ◯ No	To	From
Other	◯ Yes ◯ No	To	From

8 Workers' compensation information

a) Is the current disability due to a work related accident or illness? ◯ Yes ◯ No
If yes, has a claim been filed with any type of workers' compensation board? ◯ Yes ◯ No

b) Please provide a copy of the accident/illness report, and provide the following information.

Workers' compensation board contact name | Phone number ( ) | Fax number ( )

Claim number | Date benefit commenced (dd/mmm/yyyy) | Date benefit ceased (dd/mmm/yyyy)

9 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

Please attach any medical or other information provided to or obtained by you, relative to the plan member's absence.

10 Declaration

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

Plan administrator signature	Title

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 Financial 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.

Note: Please see next page and ensure the remainder of this form is completed.

Please ensure that the remainder of this form is completed by the plan member's supervisor.

Sections 11 - 15 may be separated from the rest of the form, if necessary.

11 Plan member identification

Please provide this information again if you plan to separate sections 11 to 15 for the plan member's supervisor to complete.

Plan contract number

Name (last, first, initial)

◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.

Plan member certificate number | Class | Division number

12 Work information

THIS SECTION TO BE COMPLETED BY THE PLAN MEMBER'S IMMEDIATE SUPERVISOR. Please enclose a detailed job description for the plan member. The description must be for the job the plan member was performing immediately prior to the date last worked.

a) What was the plan member's job title as of the last day worked?

Job title

b) How long has the plan member held this position?

Position held

years months

c) How long is the plan member's usual work day?

Length of plan member's work day

d) What is the usual work pattern? (i.e. number of shifts worked per week)

Plan member's usual work pattern

e) What are the **primary duties** of the plan member's job? (e.g. operate machinery, do research/analysis, handle shipping/receiving, do sales activities, has management/supervising responsibilities, perform customer service duties, maintain electrical/mechanical equipment, use a computer, etc.)

PRIMARY DUTIES	TIMES	**OR**	HOURS PER DAY

f) Please list any office machines, tools or other equipment that the plan member uses in this job.

TYPE OF EQUIPMENT	**SELDOM (< 1 hr.)**	**INFREQUENT (1 - 2 hrs.)**	**OCCASIONAL (2 - 4 hrs.)**	**FREQUENT (4 - 6 hrs.)**	**CONSTANT (> 6 hrs.)**
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯

13 Job requirements

a) In this section we are gathering information about the plan member's specific physical or psychological job tasks. If you have a physical or psychological demands analysis, please provide it, **OR** complete the following section as applicable.

PHYSICAL DEMANDS OF JOB

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
Sitting	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯	◯
Bending/Squatting	◯	◯	◯	◯	◯	◯
Crouching	◯	◯	◯	◯	◯	◯
Crawling	◯	◯	◯	◯	◯	◯
Pushing	◯	◯	◯	◯	◯	◯
Pulling	◯	◯	◯	◯	◯	◯
Fine manipulation; fingers	◯	◯	◯	◯	◯	◯
Simple grasping	◯	◯	◯	◯	◯	◯
Fine manipulation	◯	◯	◯	◯	◯	◯
Fine manipulation; hands	◯	◯	◯	◯	◯	◯
Repetitive body motions	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯
Reaching - above shoulder	◯	◯	◯	◯	◯	◯
Reaching - at shoulder level	◯	◯	◯	◯	◯	◯
Reaching - below shoulder	◯	◯	◯	◯	◯	◯
Reaching - side to side	◯	◯	◯	◯	◯	◯
Reaching - up and down	◯	◯	◯	◯	◯	◯

Lifting / Carrying	N/A	0 - 10 lbs 0 - 4.5 kg	11 - 20 lbs 4.6 - 9 kg	21 - 50 lbs 9.1 - 23 kg	> 50 lbs > 23 kg	FREQUENCY
Lifting - floor to waist	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - waist to shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - above shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Carrying	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant

Are assistive devices ◯ utilized ◯ available ◯ N/A

Is your plan member required to work in any of the following conditions?	Yes	No
Exposure to marked changes in temperatures and humidity	◯	◯
Being around moving machinery	◯	◯
Unprotected heights	◯	◯
Exposure to dust, fumes and gases	◯	◯
Driving automobile equipment	◯	◯
Is the plan member able to change position as comfort requires?	◯	◯

13 Job requirements (continued)

Which of the following categories best describes the psychological demands of your plan member's job?

PSYCHOLOGICAL DEMANDS OF JOB

A. Understanding and memory	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Remember locations and routine procedures	◯	◯	◯	◯	◯
Understand and remember short and simple instructions	◯	◯	◯	◯	◯
Understand and remember detailed instructions	◯	◯	◯	◯	◯

B. Sustained concentration and persistence	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Carry out short and simple instructions	◯	◯	◯	◯	◯
Carry out detailed instructions	◯	◯	◯	◯	◯
Maintain attention and concentration for extended periods	◯	◯	◯	◯	◯
Perform activities within a schedule	◯	◯	◯	◯	◯
Sustain an ordinary routine without supervision	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯
Solve simple straightforward problems	◯	◯	◯	◯	◯
Solve complex problems	◯	◯	◯	◯	◯

C. Social interaction	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Interact with the general public	◯	◯	◯	◯	◯
Ask questions or request assistance	◯	◯	◯	◯	◯
Accept instructions and feedback	◯	◯	◯	◯	◯
Get along well with others without distracting them	◯	◯	◯	◯	◯
Get along well with others without being distracted by them	◯	◯	◯	◯	◯

D. Adaptation	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Respond to frequent changes in the environment or tasks	◯	◯	◯	◯	◯
Aware of normal hazards and take appropriate precautions	◯	◯	◯	◯	◯
Travel in unfamiliar places or use public transportation	◯	◯	◯	◯	◯
Set realistic goals or make plans independently of others	◯	◯	◯	◯	◯
Juggle tasks and prioritize	◯	◯	◯	◯	◯

E. Responsibility and accountability	Yes	No
Is work pace without the pressure of deadlines?	◯	◯
Does the work involve occasional pressure to meet deadlines?	◯	◯
Does the work involve periodic pressure to meet deadlines?	◯	◯
Does the work involve significant pressures?	◯	◯

b) Before the plan member stopped working, did the illness or injury cause him/her to change:

		Date (dd/mmm/yyyy)	Explanation
Job duties	◯ Yes ◯ No		
Job performance	◯ Yes ◯ No		
Equipment	◯ Yes ◯ No		
Environment	◯ Yes ◯ No		
Hours of work	◯ Yes ◯ No		
Attendance	◯ Yes ◯ No		

14 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

15 Declaration

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

Authorized signature	Title

Telephone	Date (dd/mmm/yyyy)	
( )		Print

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial 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.