Manulife Financial

For your future™

Initial Attending Physician 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 your patient's waiver of premium claim.

See page 2 for instructions.

The eligibility process for Waiver of Premium

In assessing eligibility for Waiver of Premium benefits, we gather information from you, your patient and your patient's employer to compare restrictions and limitations with job demands.

Patient authorization

Your patient is required to complete, sign and date the patient authorization section at the top of page 3 before it can be submitted to Manulife Financial.

What do we need from you?

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

Payment responsibility

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

Submitting forms

You may give the completed form to your patient or send it directly to Manulife Financial, Group Benefits, Premium Waiver Claims, at the address indicated below.

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

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Group Benefits
Initial Attending Physician Statement
Waiver of Premium

1 Patient authorization

To be completed by patient.

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

I hereby authorize the release, to my insurer, of any medical information in my file, including copies of hospital records, with respect to this claim. I understand I am responsible for any fees related to the completion of this form.

Patient signature	Date (dd/mmm/yyyy)

2 Attending physician statement

Diagnosis

a) Primary diagnosis

b) Additional diagnoses or complications

c) ***If*** psychiatric disorder, provide current GAF score.

GAF score

d) ***If*** cardiac disorder, provide American Heart Association functional classification.

◯ Class I (No limitation) ◯ Class II (Slight limitation)
◯ Class III (Marked limitation) ◯ Class IV (Complete limitation)

3 Clinical information

Please note that we need you to identify your patient's limitations and the impact of those on your patient's functional capabilities. To enable our adjudicators to assess the disability arising from these limitations, please provide supportive documentation such as reports, chart notes and test results.

a) What date did symptoms first appear/accident happen? (dd/mmm/yyyy)

b) When did your patient's condition begin? (dd/mmm/yyyy)

c) Is this condition due to:

◯ Injury ◯ Work-related ◯ Motor vehicle accident ◯ Other (specify) ▶
◯ Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)	Date of latest visit (dd/mmm/yyyy)

Frequency of visits
◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Other (specify) ▶

e) What are the patient's subjective ***symptoms?***

3 Clinical information (continued)

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity.)

g) What were your initial ***clinical findings?***

h) What are your most recent ***clinical findings?***

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

◯ Ambulatory
◯ Ambulatory with assistive devices
◯ Bed confined
◯ Home confined
◯ Hospital confined

k) What is the patient's current height and weight, and dominant hand?

Current height
_____m _____cm / _____ft _____in

Current weight ◯ kg ◯ lb

Dominant hand ◯ Left ◯ Right

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)	Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)		

m) ***If*** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD OS	Without corrective lenses OD OS	Date of last exam (dd/mmm/yyyy)

n) ***If*** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

Please enclose copies of any and all consultation and diagnostic investigative reports (X-rays, scans, laboratory data, etc.).

a) Names of other treating/consulting physicians or health care practitioners

NAME OF PRACTITIONER/PHYSICIAN	TYPE OF PRACTITIONER/PHYSICIAN	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	REASON (date of surgery if applicable)

d) Hospitalizations

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	RESPONSE

e) Treatment response

◯ Recovered
◯ Improved
◯ No change
◯ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

◯ Yes ◯ No ***If no, please elaborate.***

4 Treatment (continued)

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

◯ Yes ◯ No ***If no, from what date?***

(dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

◯ Yes ◯ No

◯ Restricted ◯ Suspended ◯ Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/information that you believe may help us understand your patient's restrictions and limitations, functional capabilities, expected duration of impairment, etc.

Physician's acknowledgement and authorization

Name of attending physician (please print)

Specialty

Telephone ( ) Ext.

Fax ( )

Address (number, street, suite)

City

Province

Postal code

Signature

Dated signed (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 patient 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.