

Group Benefits Plan Member Statement Group Disability Claim Form

Please send completed form to:

Manulife Group Benefits

Attention: Disability Claims

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

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form. Refer to your booklet for information about your plan.

1 Benefit application

Please select the benefit type for which the plan member is applying.

- Short term disability Long term disability Waiver of premiums Critical illness Dismemberment

2 Plan member information

You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.

Plan sponsor name **Glencore Canada Corporation**

Plan contract number _____ Division _____ Certificate number _____

Full name (first, middle initial, last) _____

SIN (if benefit is taxable) _____ Date of birth (dd/mmm/yyyy) _____ Sex _____

Height _____ Weight _____ Number of dependents and ages _____ Language preference: English French

Street address (number, street, apt) _____

City _____ Province _____ Postal code _____

Primary phone number _____ Alternate phone number _____

Work phone number _____ Ext. _____

By providing my personal email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

Email address _____

3 Direct deposit authorization

If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.

If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement

If depositing into a chequing account, please sign the authorization, and attach a copy of a void cheque

Name of financial institution _____

Address of financial institution (number, street, suite) _____

City _____ Province _____ Postal code _____

Type of account: Chequing Savings

Branch or transit number (5 digits) _____ Institution number (3 digits) _____

Bank account number (maximum 12 digits) _____

Continued on the next page.

3 Direct deposit authorization (continued)

I hereby authorize Manulife to deposit, until further notice, payment 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. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan member signature _____ Date (dd/mmm/yyyy) _____

Plan member name (please print) _____



If providing a copy of a void cheque, please place it here.



4 Injury information

Occupation _____ Original date of hire (dd/mmm/yyyy) _____

Is your injury/illness work related? Yes No

If no, was the reason you stopped working due to: Illness Injury away from work Motor vehicle accident
(Please provide a copy of the police report)

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

Is there any legal action? Yes No If yes, please provide the lawyer's contact information.

Lawyer's name _____ Phone number _____ Ext. _____

Lawyer's address (number, street, suite) _____

City _____ Province _____ Postal code _____

5 Work information

What was the last date at work? (dd/mmm/yyyy) _____

Was this a full day/shift? Yes No If no, how many hours were worked on your last day? _____

Have you performed any other paid or volunteer work since that date? Yes No

If yes, please describe.	Dates (dd/mmm/yyyy)	
_____	From _____	To _____
_____	From _____	To _____
_____	From _____	To _____
_____	From _____	To _____

6 Illness information

When were you first treated by a physician for the current absence? (dd/mmm/yyyy) _____

Please describe your symptoms and their frequency.

What work duties do your symptoms prevent you from performing?

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

Did it result in an absence from work? Yes No If yes, please describe, include dates and treatment provided.

Do you have an expected return to work date? Yes No If yes, please provide the date (dd/mmm/yyyy) _____

7 Health care professional information

Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number _____ Fax number _____

Consulted: From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number _____ Fax number _____

Consulted: From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name _____ Specialty _____

Address of health care professional (number, street, suite) _____

City _____ Province _____ Postal code _____

Phone number _____ Fax number _____

Consulted: From: (dd/mmm/yyyy) _____ To: (dd/mmm/yyyy) _____

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

8 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?		Date benefit commenced? (dd/mmm/yyyy)	Amount (\$)	Please describe or provide claim number, contact name and telephone number
	Yes	No	Yes	No			
Canada/Quebec Pension Plan							
○ Disability	○	○	○	○	_____	_____	_____
○ Retirement							
Worker's compensation*	○	○	○	○	_____	_____	_____
Employment insurance	○	○	○	○	_____	_____	_____
Auto insurance	○	○	○	○	_____	_____	_____
Other insurance	○	○	○	○	_____	_____	_____
Income from any other source	○	○	○	○	_____	_____	_____

*Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

9 When to contact Manulife

NOTIFY MANULIFE PROMPTLY IN THE FOLLOWING CASES

Acknowledge I must notify Manulife immediately if:

- a) my medical condition improves, even though I have not yet returned to work
- b) I start work either as an employee or a self-employed person
- c) I apply for benefits under any workers' compensation law or plan as defined in section 8
- d) I apply for benefits under Canada/Quebec Pension Plan
- e) I receive any benefits or income from any other source
- f) I am admitted or discharged from hospital
- g) I receive any other benefits/income related to my disability
- h) I am leaving the country or traveling
- i) I am or will be returning to school

Plan member signature _____ Date (dd/mmm/yyyy) _____

10 Agreement, authorization and acknowledgement

Please sign this authorization and send to Manulife using one of the following methods.

- Via fax:** (519) 579-3680 or 1-866-677-4215
- Via email:** group_disability_claims@manulife.com
- Via regular mail to:** **Manulife Group Benefits**
Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2

I confirm:

- 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.
- that my claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- I am required 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 monies from my group benefits.

Re: Manulife

I authorize:

- Manulife and/or its service providers, its reinsurers and its service providers, and 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 and administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claim(s), including independent medical assessments.
- Manulife to use my SIN for the purposes of tax reporting and identification and administration, if my SIN is used as my plan member certificate number.
- Manulife to release information to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor for plan administration purposes.

I acknowledge:

- that my medical information will not be provided to my employer unless my consent is explicitly obtained as described below.

I confirm:

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- I understand 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, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or from my plan sponsor.

I acknowledge:

- 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 or disclosure of 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 or authorized disclosure; 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.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife. I understand that withdrawing this consent may impact Manulife's ability to administer the plan, benefits may be impacted and Manulife may treat my withdrawal of consent as a request to terminate my benefits.

Signature _____ Date (dd/mmm/yyyy) _____

10 Agreement, authorization and acknowledgement (continued)**Glencore**

I expressly authorize Manulife to disclose to and exchange with the Glencore Occupational Health Services, my personal health information relating to my present medical condition, degree of impairment, treatment plan, functional abilities, restrictions, functional limitations, and any obstacles to return to work that are identified through the adjudication and rehabilitation process. This information will only be disclosed when relevant for the purpose of assisting with the assessment of my claim(s), determining my fitness to return to work, discussing rehabilitation, and developing early intervention strategies to support and assist with return to work planning.

I understand, I may withdraw my consent for Manulife to disclose medical information to the Glencore Occupational Health Services at any time by sending a written instruction to Manulife. I understand that withdrawing this consent may impact my employer's ability to assist me with return to work planning.

Signature _____ Date (dd/mmm/yyyy) _____



Attending Physician Statements

- Short Term Disability Claim
- Long Term Disability Claim
- Waiver of Premium Claim for:
 - Basic & Optional Life Benefit
 - AD&D Benefit
 - Survivor Benefit

Please ensure to have your physician complete the appropriate Attending Physician Statement for submission of your disability claim.

	If applying for a Short Term Disability (STD) claim:	Please have your physician complete the attached Attending Physician Statement – Short Term Group Disability Claim (pages 7 & 8)
	If applying for a Long Term Disability (LTD) and/or a Waiver of Premium and/or a Dismemberment claim:	Please have your physician complete the attached Attending Physician Statement – Long Term Disability Claim (pages 9-13)
	If applying for a Critical Illness claim:	Please refer to your Plan Member secure website to print the Attending Physician’s Statement corresponding to the condition.

Please send the completed Attending Physician Statement to the following address:

Manulife Group Benefits
Attention: Disability Claims
 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

Note: You are responsible for payment of any fees associated with completion of this form and accompanying documentation.

Group Benefits

Attending Physician Statement

Short Term Group Disability Claim

The purpose of this Statement is to assist Manulife in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO
Waterloo ON N2J 4C2

Tel: 1-877-481-9169 • (519) 747-7000
Fax: 1 866 677-4215 • (519) 579-3680
Email: group_disability_claims@manulife.com

1 Plan member/employee information and consent (To be completed by patient.)

Plan member/employee name (last, first, middle initial)		Home phone number	Cell phone number
Address (number, street, apt.)		City	Province Postal code
Plan sponsor name Glencore Canada Corporation		Plan contract number	Plan member certificate number
Height	Weight	Date of birth (dd/mmm/yyyy)	
Last date worked (dd/mmm/yyyy)		Date returned to work or expected return to work date (dd/mmm/yyyy)	

I hereby authorize the release of medical and health information in my file to Manulife and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. **I understand** that I can revoke this consent at any time but that without it my claim may not be assessed. **I understand** that I am responsible for any fees related to the completion of this form. **I agree** that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Plan member/Employee signature _____ Date (dd/mmm/yyyy) _____

2 Attending physician's statement

NOTE TO PHYSICIAN:

- If your patient has returned to work or will return to work within 4 weeks of the **last date worked**, complete **section 2 only** and **sign** at the end of the form.
- For absences expected to be greater than 4 weeks, please complete **all sections** in full.

Diagnosis
 Primary: _____
 Secondary: _____

If childbirth provide expected or actual delivery date (dd/mmm/yyyy)

 Vaginal C-Section

Occupational illness/injury
 Is condition arising from employment? Yes No

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)
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Hospitalization
 Is/was patient hospitalized or had day surgery Date admitted (dd/mmm/yyyy): _____
 Name of institution: _____ Date discharged (dd/mmm/yyyy): _____

If surgery was performed provide date and description of surgery.
 Date (dd/mmm/yyyy): _____ Description: _____

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes No If yes, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of Visits Weekly Monthly Other _____



Attach copies of all relevant:
 • test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - **do not provide genetic test results**
 • consultation reports

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit _____

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

To your knowledge, is the patient following the recommended treatment program? Yes No

In your opinion, is your patient competent to manage his/her own affairs? Yes No

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with Manulife 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 I consent to such unedited release of any information contained herein.

Attending physician (please print)		Certified specialist		Physician's stamp
Address (number, street, suite)				
City	Province	Postal code		
Telephone number	Fax number			
Signature			Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

Group Benefits Attending Physician Statement

- Long Term Disability Claim
- Waiver of Premium Claim for:
 - Basic & Optional Life Benefit
 - AD&D Benefit
 - Survivor Benefit

An incomplete form may result in delays in the adjudication of your patient's disability claim.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

Patient authorization

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 10 before it can be submitted to Manulife.

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, Group Disability Benefits, at the address indicated below.

Manulife Group Benefits
Attention: Disability Claims
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

Group Benefits Attending Physician's Statement Group Disability Claim

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Division number	Plan member certificate number
<p>"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 this form."</p>		
Patient's signature		Date (dd/mmm/yyyy)

2 Attending physician's 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 your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results (excluding genetic tests) in support of your patient's diagnosis and functional abilities.

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**?

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

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

Blank text area for initial clinical findings.

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

Blank text area for 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.

Blank text area for physical limitations.

(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.

Blank text area for cognitive or psychiatric limitations.

j) Is your patient:

Ambulatory Bed confined Hospital confined
 Ambulatory with assistive devices Home confined

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

Current height: _____ Current weight: _____ 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)
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n) **If** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

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

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	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)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

<input type="radio"/> Recovered <input type="radio"/> Improved <input type="radio"/> No change <input type="radio"/> Retrogressed	Comments

f) Is your patient following the recommended treatment program?

<input type="radio"/> Yes <input type="radio"/> No	If no, please elaborate:

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?

Date (dd/mmm/yyyy)

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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)

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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.

Name of attending physician (please print)

Specialty

Telephone (include area code)

Fax (include area code)

Address (number, street and suite)

City

Province

Postal code

Signature

Date signed (dd/mmm/yyyy)

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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 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.