Manulife Financial

Return completed form to your employer, Canadian Pacific Railway

Manulife Financial
Disability Call Centre:
1-877-481-9169

Employee Statement

Weekly Indemnity Benefit – Group Disability Claim for Unionized Employees of Canadian Pacific Railway

- Please complete and forward to your employer.
- Please print clearly and answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- **Please complete the Patient Authorization section and have your doctor complete the Attending Physician's Statement form and return the physician statement directly to Manulife Financial.**
- This claim form must be completed and submitted within 30 days of the onset of disability.

1 Employee Information

Plan Number: *84500*

Employee (Certificate) Number

Union

Company Name: ***Canadian Pacific Railway***

Job Occupation ○ Safety Sensitive ○ Safety Critical

Employee's Full Name (Last Name, First Name, Middle Initial) ○ Mr. ○ Ms. ○ Miss ○ Mrs.

Birth Date (dd/mm/yyyy)

Social Insurance Number

Preferred Language ○ English ○ French

Full Address (Street Number and Name, Apartment or P.O. Box Number)

City

Province

Postal Code

Telephone Number ( )

Fax Number ( )

2 Claim Information

Last Day Worked (dd/mm/yyyy)

Is the condition due to an accident? ○ Yes ○ No *If no, please go to Section 3, Medical Information*

What kind of accident?

○ Motor Vehicle Accident ○ Work Related ○ Other

Name of Motor Vehicle Insurance Carrier

Contact Person

Contact Person's Telephone Number ( )

Describe how and when injury occurred.

Date of Accident

Time of Accident ○ am ○ pm

Is there any legal action involved?

○ Yes ○ No *If yes, please provide the following information*

Lawyer's Name

Telephone Number ( )

Was the occurrence investigated by the police?

○ Yes ○ No *If yes, please provide a copy of the police report.*

3 Work Information

What are your job duties (e.g., operate machinery)?

When do you expect to return to your job?

Date (dd/mm/yyyy)

If you are still disabled after 15 weeks, you may be eligible to receive employment insurance (EI) sickness benefits for up to an additional 15 weeks while disabled. You must submit an application for EI Sickness benefit through your local Employment Insurance office when you reach week 14 of your weekly indemnity period. Sickness benefits payable under the EI Act are eligible for "top-up" to the WIB maximum amount (EI assessment must be provided to Manulife Financial).

4 Income/Benefit Information

Have you applied for or are you receiving any of the following income/benefits. *If so, please provide copies of pay slips and/or award letters, including decline letters.* It is important that all sources of income be reported immediately. It is possible that these may impact potential benefit payment.

INCOME BENEFIT	REFERENCE OR CLAIM NO.	BENEFIT DATE (dd/mm/yyyy) START / END	FREQUENCY WEEKLY	BI-WEEKLY	MONTHLY	LUMP SUM	AMOUNT
Any type of Workers' Compensation Board*			○	○	○	○	$
Motor Vehicle Insurance			○	○	○	○	$
Employment Insurance			○	○	○	○	$
Other			○	○	○	○	$

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

5 Assignment, 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 agree to refund any monies that may be due to Manulife Financial as a result of disability benefits from any source listed above and/or in accordance with the provisions of the group benefits plan with Manulife Financial.

I understand that Manulife Financial (which hereinafter includes its claim service providers and reinsurers) and/or my employer may investigate this claim and may require information relevant to my claim including but not limited to information regarding my employment, benefit payment information, my activities and my health and health history, including clinical notes and medical records. I authorize any person or organization, including any employer, health care professional, health care institution and any other medically-related facility, rehabilitation provider, insurer, administrator of government benefits or other benefit programs, the Medical Information Bureau or investigative agency, to release and exchange any information or documentation requested by Manulife Financial and/or my employer for the purposes of administering the group plan, assessing, auditing, investigating and managing my claim or return to work, or for the purpose of transitioning my claim to a long term disability plan.

I authorize Manulife Financial and /or my employer, including the Office of the Chief Medical Officer of Canadian Pacific Railway, to collect, use and exchange with the persons or organizations listed above and/or with each other any information or documentation, including any medical or disability related records for the purposes listed above. I understand that only information related to my work restrictions will be transmitted to my supervisor.

I authorize the use of my Social Insurance Number for the purpose of tax reporting. 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 Financial's privacy policies is available upon written request, or on Manulife Financial's website www.manulife.ca.

Employee Signature	Date Signed (dd/mm/yyyy)

At Manulife Financial, 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.

Manulife Financial

CANADIAN PACIFIC RAILWAY

Employer Statement

Weekly Indemnity Benefit – Group Disability Claim for Unionized Employees of Canadian Pacific Railway

Return completed form to:
Waterloo Group Disability Claim Office
25 Water Street South, P.O. Box 800
KITCHENER ON N2G 4Y5

Manulife Financial
Disability Call Centre:
1-877-481-9169
Fax: 1-519-744-4519

- To be completed by the employer.
- Please print clearly and answer all questions.
- **Please attach details on any additional information that you believe should be considered in assessing this employee claim.**
- Provide the employee with an Employee Statement form and an Attending Physician's Statement form for the family physician or attending specialist.

1 Employer

Plan Number: *84500*
Acct/Div. No. (Union)
Company Name: *Canadian Pacific Railway*
Address (Street Number and Name, Apartment or P.O. Box Number)
City
Province
Postal Code
Contact Name
Title
Telephone Number ( )
Fax Number ( )

2 Employee Identification

Name (Last Name, First Name, Middle Initial)
○ Male ○ Female
Social Insurance Number
Employee (Certificate) Number
Date of Birth (dd/mm/yyyy)

3 Employee Information

Date of Hire (dd/mm/yyyy)
Date Eligible for Benefit (dd/mm/yyyy)
Department
Employee's Job Title ○ Safety Sensitive ○ Safety Critical
Union Affiliation of Employee
Name of Employee's Supervisor/Manager
Telephone of Supervisor/Manager
Date Last Worked (dd/mm/yyyy)

Reason Employee Stopped Working
○ Illness ○ Injury ○ On layoff ○ Leave of absence ○ Maternity leave ○ Other ______________________

Has the employee returned to work?
○ Yes ○ No *If yes, please provide date returned to work.* (dd/mm/yyyy)

If no, please provide expected return date (dd/mm/yyyy)

Has benefit coverage terminated?
○ Yes ○ No *If yes, please state when and reason why.*

Date Benefit Coverage Terminated (dd/mm/yyyy)
Reason for Termination of Benefit Coverage

4 Employee's Earnings and Benefit Information

It is important all sources of income be reported immediately. It is possible that these may impact potential benefit payment.

*Please provide the following information **OR** a copy of the current pay slip.*

Weekly Salary/Wage When Employee Was Last At Work	Date of Last Salary Change (dd/mm/yyyy)
$	

Other Income, if Applicable
$

Is employee on spare board, relief, or casual employment? ◯ Yes ◯ No ◯ Other ______________

If yes, please attach a list of employee's earnings during the six (6) consecutive complete pay periods in which the employee received earnings immediately preceding disability. (Show clearly any vacation dates and the pay thereof. It may be necessary to go beyond six (6) periods to obtain six (6) periods in which payment was received.)

5 Tax Information

Please complete as benefit is taxable.

*Please provide the following information, **OR** a completed TD1 or TP1 form.*

TD1 (Federal)	TP1 (Provincial)	Employee province of residence for income tax purposes

6 Additional Earnings

Please indicate if any of the following have been paid.

INCOME BENEFIT	PAID/ PAYABLE		WEEKLY	PAID FROM (dd/mm/yyyy)	PAID TO (dd/mm/yyyy)	AMOUNT
	Yes	No				
Vacation Pay	◯	◯	◯			$
Severance	◯	◯	◯			$
General Holiday	◯	◯	◯			$
Retirement or Pension	◯	◯	◯			$
Other	◯	◯	◯			$

7 Workers' Compensation Information

Is the current condition due to a work related accident or illness? ◯ Yes ◯ No

If yes, please explain

If yes, please provide a copy of the information received from any type of Workers' Compensation Board.

8 Work Information and Job Requirements

Work Information and job requirements, including primary duties and physical demands specific to job tasks will be gathered by CPR as a separate process and forwarded to Manulife Financial's Disability Claims department for adjudication and return to work purposes. Work information and job requirements are not required to be provided through this form.

9 Declaration

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

Authorized Signature	Title

Telephone Number	Date (dd/mm/yyyy)
( )	

The information in this statement will become part of a group life and health benefits file which might be accessible by the employee or third parties to whom access has been granted or those authorized by law.

CANADIAN PACIFIC RAILWAY

Return completed form to:
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KITCHENER ON N2G 4Y5

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Attending Physician's Statement
Weekly Indemnity Benefit – Group Disability Claim for Unionized Employees of Canadian Pacific Railway

The primary purpose of this statement is to assist Manulife Financial in making a decision about your patient's claim for disability benefits. The secondary purpose is to assist your patient in returning to work under the terms of CPR's Return To Work program.

When completing this form, please include sufficient details of history, physical and diagnostic findings, critical course, therapy, and response to enable Manulife Financial 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.

The primary goal of Canadian Pacific Railway's Return To Work Program is to assist employees who are absent from work due to medical reasons, to return to work and/or remain at work. This program includes modified or alternate duties for employees with temporary or permanent restrictions. Many positions occupied by Canadian Pacific Railway employees are critical to safe railway operations and impact on the safety of the public and/or other employees. Delay in processing of this claim may delay or prevent employees from returning to work.

The employee must complete Sections 1 and 2, then have the Attending Physician complete the remaining Sections.

1 Patient Authorization
(To be completed by patient)

Name of Patient (Last name, First Name, Middle Initial)	Group Plan Number *84500*	Employee (Certificate) Number
Address (Street Number and Name, Apartment or P.O. Box Number)		
City	Province	Postal Code
Date of Birth (dd/mm/yyyy)	Height	Weight

I hereby authorize the release to my insurer, the office of the Chief Medical Officer of Canadian Pacific Railway, of any medical information in my file with respect to this claim.

Patient's Signature	Date (dd/mm/yyyy)

2 Medical Information
(To be completed by patient)

List all doctors consulted for your present condition.

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mm/yyyy)
Address of Doctor (Street Number and Name)	Suite	Date of Next Visit (dd/mm/yyyy)
City / Province	Frequency of Visits	
Postal Code / Telephone Number ( )	Type of Practitioner	

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mm/yyyy)
Address of Doctor (Street Number and Name)	Suite	Date of Next Visit (dd/mm/yyyy)
City / Province	Frequency of Visits	
Postal Code / Telephone Number ( )	Type of Practitioner	

3 Attending Physician's Statement

Rest of form to be completed by physician

A. History

○ Safety Sensitive Position ○ Safety Critical Position

When did symptoms first appear or the incident happen? Date (dd/mm/yyyy)

What date did patient cease work because of illness/injury? Date (dd/mm/yyyy)

Has the patient ever had the same or a similar condition? ○ Yes ○ No

If "Yes" state when and describe

Is condition due to injury or sickness arising out of patient's employment? ○ Yes ○ No ○ Unknown

Is a claim being submitted to any type of Workers' Compensation Board? ○ Yes ○ No

Has the patient been confined in a hospital?
If available, please include admission and discharge summaries. ○ Yes ○ No

If Yes

Admission date (dd/mm/yyyy)	Discharge date (dd/mm/yyyy)
Admission date (dd/mm/yyyy)	Discharge date (dd/mm/yyyy)
Admission date (dd/mm/yyyy)	Discharge date (dd/mm/yyyy)

Name, Specialty and address of other treating physician(s)

Name	Specialty	Address

B. Diagnosis

a) Primary

b) List any additional conditions or complications

c) Subjective symptoms

d) Objective findings/Physical examination **(please include copies of current x-rays, EKG's or laboratory data and any relevant physical findings and consultation reports.)**

If your patient is/was pregnant, please provide the expected/actual delivery date (dd/mm/yyyy)

4 Treatment

Frequency of Visits			
Weekly	Date of First Visit (dd/mm/yyyy)	Date of Last Visit (dd/mm/yyyy)
Monthly	Date of all visits between first and last visit (dd/mm/yyyy)	
Other (specify)		

Nature of Treatment (including surgery, physiotherapy, psychotherapy)

Medications	Dosage	Side Effects	Duration

When do you expect a significant change in the functional limitation affecting your patient?

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

Is there potential for future improvement? ○ Yes ○ No

If no, please comment.

Have you recommended that your patient's driver's license be revoked? ○ Yes ○ No

5 Physical impairment

Does your patient have a physical impairment?

◯ Yes ◯ No

If yes, please complete this section.

Based on objective findings please describe your patient's abilities in the following areas:

Lifting	(max. weight/frequency)	Sitting	(how long/frequency)
Carrying	(max. weight/distance)	Standing	(how long/frequency)
Pushing/Pulling	(max. weight/frequency)	Walking	(distance/frequency)
Walking on Uneven Ground	(distance/frequency)	Climbing	(how long/frequency)
Working at Heights	(distance/frequency)		

Remarks

6 Cognitive/Mental Impairment

Does your patient have a cognitive/mental impairment?

◯ Yes ◯ No

If yes, please complete this section.

Indicate if patient has cognitive/mental restrictions in the following areas.

	None	Mild	Moderate	Severe
◯ Concentration (example attention, orientation)				
◯ Analytical Reasoning (example judgement)				
◯ Learning New Material (example memory)				
◯ Comprehension				
◯ Social Interaction (example mood)				
◯ Reaction Time				
◯ Ability to Process Information and React Appropriately				

What is the DSM IV diagnosis? (Axis 1)

What is the current GAF?

Remarks

Please provide copies of consultation reports and your most recent mental status results and list all abnormal findings supporting the above restrictions.

Competency

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ◯ Yes ◯ No

7 Cardiac (if applicable)

Please include cardiac investigations.

a) Functional capacity (American Heart Association)

◯ Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.
◯ Class 2 - Greater than ordinary physical activity results in symptoms.
◯ Class 3 - Ordinary physical activity results in symptoms.
◯ Class 4 - Symptoms at rest, and worse with physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC
SYSTOLIC / DIASTOLIC
SYSTOLIC / DIASTOLIC

8 For Canadian Pacific Railway Occupational Health Services

(To be completed by attending physician)

Based on any restrictions listed above, is your patient fit to return to **modified duties**?	◯ Yes ◯ No	(dd/mm/yyyy)
Based on any restrictions listed above, is your patient fit to return to **gradual duties**?	◯ Yes ◯ No	(dd/mm/yyyy)
Based on any restrictions listed above, is your patient fit to return to **regular duties**?	◯ Yes ◯ No	(dd/mm/yyyy)
Duration of restrictions	(dd/mm/yyyy)	

In your opinion, is your patient capable of performing duties that are critical to his/her own safety or to the safety of others? ◯ Yes ◯ No

If your patient is unfit for work at this time, when is the next reassessment date? (dd/mm/yyyy)

Estimated Return to Work Date (dd/mm/yyyy)

Prognosis for Return to Work

9 Comments

10 Physician's Authorization

NOTICE: By completing this physician's statement, information contained herein will become part of a GROUP LIFE, HEALTH AND DISABILITY file with Manulife Financial and might be accessible by the patient through a designated health care professional of their choice, Manulife Financial employees, or third parties as permitted by law. By providing the information, you consent to such unedited release of any information contained herein.

Attending Physician (please print)

Certified Specialist		Telephone (include area code) ( )
Address (Street Number, Apartment or P.O. Box Number)		Fax (include area code) ( )
City	Province	Postal Code
Signature		Date Signed (dd/mm/yyyy) ( )

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THE FORM, IN THE PROVINCES WHERE APPLICABLE