Manulife

Nova Scotia Public Service
Long Term Disability Plan Trust Fund

Group Benefits Plan Member Statement
Group Disability Claim Form

Manulife is committed to keeping information confidential. Disability benefits under this plan are self-insured by the Nova Scotia Public Service LTD Plan Trust Fund, ("the LTD Fund"), which means it funds the claims. Manulife provides disability administration services such as initial claims assessment and ongoing case management based on the terms of the Nova Scotia Public Service Long Term Disability Plan, ("the LTD Plan").

- **Please ensure to answer all questions.**
- **Additional statements may be submitted if there is insufficient space on this form.**

Please send completed form to:

Manulife Group Benefits
Attention: Disability Claims
P.O. Box 1030 Station Central, Halifax, Nova Scotia B3J 2X5
Tel.: 1-800-565-0627 Fax.: 1-866-292-9050
Email: **group_disability_claims@manulife.ca**

1. Benefit application

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

☑ Long term disability

2. Plan member information

Department/Employer name: _____ Plan contract number: **84560**

Full name (first, middle initial, last): _____

SIN: _____ Date of birth (dd/mmm/yyyy): _____

Sex*: ◯ Male ◯ Female ◯ Non-binary

* Select male, female or non-binary consistent with your current biological sex.
For the purpose of this application, non-binary does not refer to an individual's sexual orientation, gender identity, gender expression or gender perception.

Height: _____ Weight: _____ Number of dependants 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 a ddress: _____

3. Direct deposit authorization

Please complete this section to receive 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. 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. Consent to Collection, Use and Disclosure of Personal Information

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

Via fax: 1-866-292-9050

Via email: **group_disability_claims@manulife.ca**

Via regular mail to: **Manulife Group Benefits**
Attention: Disability Claims, P.O. Box 1030 Station Central, Halifax, Nova Scotia B3J 2X5

I confirm that:
- The information provided in this form, and any further verbal or written information I provide in the future, is true, accurate, and complete to the best of my knowledge.
- I understand that my claim(s) and/or coverage may be denied, suspended, or terminated if I provide false, incomplete, or misleading information.
- I understand that I may be required to repay amounts paid to me in accordance with the provisions of the Long Term Disability ("LTD") Plan administered by Manulife, and I authorize Manulife to deduct monies from any LTD benefits
- A photocopy or electronic version of this authorization shall be considered as valid as the original.

You will tell us right away if:
- your medical condition improves, even if you haven't returned to work
- you receive any benefits or income from any other source
- you start work as an employee or as a self-employed person
- you apply for any workers' compensation benefits
- you apply for benefits under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)
- you leave the country or travel within the country
- you're returning to school, or will be returning to school
- you are admitted to or discharged from a hospital

Authorization and Consent
I hereby authorize and consent to the collection, use, and disclosure of my personal information as described below.

Collection, Use and Disclosure
Manulife and/or its service providers, reinsurers, and service providers of such entities, as well as any person or organization that has personal information about me (including administrators of government benefit programs or other benefit programs), may collect, use, and disclose my personal information for the following purposes:
- determining eligibility for LTD benefits;
- assessing, investigating, and evaluating medical, functional, vocational, and financial information relevant to my claim(s);
- coordinating benefits with other insurers or benefit programs;
- administering, auditing, and managing my claim(s) and the LTD Plan; and
- complying with applicable legal, regulatory, and contractual obligations, including independent medical assessments where required.

Your social insurance number (SIN)
Where Manulife is responsible for payment of benefits, you authorize the use of your SIN:
- for tax reporting

Disclosure to Third Parties
I authorize Manulife to disclose my personal information to the Office of the LTD Fund, reinsurers, service providers, medical or vocational professionals, government programs, and other third parties involved in the administration of my LTD claim or the LTD Plan, where such disclosure is reasonably required to carry out the purposes described above.

Continued on the next page.

9. Consent to Collection, Use and Disclosure of Personal Information (continued)

Consent to Share Contact Information
I authorize Manulife to share my contact information including mailing address, telephone number and email address with the Office of the LTD Fund for the limited purpose of supporting the administration of my Long Term Disability claim including, but not limited to;
- Providing education and awareness on additional services and support programs available to me
- Follow-up on outstanding items to ensure timely completion
- Tracking and follow-up of outstanding action items
- Coordinating follow-ups on open items with relevant stakeholders
- Monitoring and following up on pending requests

Automated or Technology-Assisted Decision-Making
I understand that certain decisions related to my claim may be assisted by automated or technological tools. I may request information about the decision-making process, submit observations, and request that the decision be reviewed.

Acknowledgement
I acknowledge and understand that:
- My personal information will not be collected, used, or disclosed for purposes other than those identified above, except with my consent or as permitted or required by law.
- Manulife's privacy practices, including information about how personal information is collected, used, disclosed, retained, de-identified, and protected, are described in Manulife's Privacy Policy, available at **https://www.manulife.ca/corporate/privacy-policy.html** or from the Office of the LTD Fund.
- Access to or disclosure of my personal information may be limited to Manulife employees, service providers, reinsurers, and other authorized persons who require the information to perform their job responsibilities, as well as to persons authorized by law.
- Any records created or maintained by Manulife in relation to my claim are the property of the LTD Fund. I authorize Manulife to collect, use, and disclose this information to the Office of the LTD Fund for purposes related to the administration of the LTD Plan as stated above.
- Where LTD benefits are funded directly by the LTD Fund and Manulife has been contracted to adjudicate and administer claims, Manulife may issue benefit payments on behalf of the LTD Fund; however, liability for LTD benefits remains with the LTD Fund.
- For my disability claim, Manulife may:
  – communicate with me and provide me with required disclosures electronically
  – use electronic records

Access, Accuracy and Withdrawals
You have the right to request access and verify your personal information maintained in our files, and to request any factually inaccurate personal information be corrected, if appropriate. You also have the right to withdraw consent to the use and disclosure of your personal information where it will not impact the provision of services or is not required at law.

To access or rectify your personal information files or withdraw consent contact (Manulife at 1-877-481-9169 or **group_disability_claims@manulife.ca**) or write to the Privacy Officer at the address below.

Chief Privacy Officer
Manulife
P.O. Box 1602
Del Station 500-4-A
Waterloo, Ontario N2J 4C6
Canada_Privacy@manulife.ca

By signing this form, you acknowledge that you have read, understood and agree to the content of this authorization, as well as the **Personal Information Statement** available at **manulife.ca**.

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

Plan member name (please print): _____

Print

Please note: The information in this statement will be kept in a group disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.