Manulife

LTD Nova Scotia Public Service Long Term Disability Plan Trust Fund

Authorization and Consent to Disclose Medical and Health Information

This consent applies only when you are requesting an Appeal Hearing of a Long Term Disability (LTD) claim decision.

Purpose of This Consent

I understand that:

- My Long Term Disability claim has been denied or terminated by Manulife and I have elected to proceed with an Appeal Hearing in accordance with the Plan's Appeal Guidelines

To allow the Office of the LTD Fund to properly support me during my appeal, Manulife must disclose my full LTD claim file

Information to Be Disclosed

I authorize Manulife to disclose to the Office of the LTD Fund my full LTD claim file to assist in my LTD appeal, which may include, but is not limited to:

- Medical reports, physician statements, and clinical notes
- Functional abilities and restrictions
- Diagnoses and treatment information
- Independent medical or vocational assessments
- Any other medical or health information relied upon by Manulife in relation to my LTD claim decision

Recipient of Information

I authorize Manulife to disclose the above information to:

- The Office of the LTD Fund

I understand that once disclosed, the information will be handled by the Office of the LTD Fund in accordance with its legal and privacy obligations.

Voluntary Consent

I understand and acknowledge that:

- Providing this consent is voluntary, but necessary if I wish to proceed with an appeal.
- If I choose not to provide this consent, the Office of the LTD Fund may be unable to make a fully informed decision regarding my appeal, and my appeal may not proceed

Scope and Duration of Consent

- This consent applies only to my current LTD appeal.
- It does not authorize disclosure for any other purpose.
- This consent remains valid until my LTD appeal process is completed, unless I withdraw it earlier in writing.
- I understand that withdrawing consent may impact the ability to continue or complete the appeal.

Acknowledgement and Authorization

By signing below, I confirm that:

I have read and understand this consent.

I authorize Manulife to disclose my medical and health information to the Office of the LTD Fund for the purpose described above.

_______________________________________ _______________________________

Name Date