

# Group Benefits Employee Declaration

## Abilities Management Access

- To be completed by the employee.
- Please print clearly and answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form (GL4936E) and photocopies of file documentation.

Please return the completed form to: **Manulife Financial Case Management Centre**  
 1095 PENDER ST W 7<sup>TH</sup> FLOOR  
 VANCOUVER BC V6E 2M6  
 Phone: 1-866-232-9673 or (604) 678-1591  
 Fax: 1-866-413-3582 or (604) 678-3389

### 1 Employee information

You can obtain your plan contract number, and your employee certificate number from your employer.

Plan contract number	Employee certificate number		
Employer's name		Job title	
Employee's full name (last, first, initial)			<input type="radio"/> Mr. <input type="radio"/> Ms. <input type="radio"/> Miss <input type="radio"/> Mrs.
Birthdate (dd/mmm/yyyy)	Preferred language: <input type="radio"/> English <input type="radio"/> French	Height	Weight
Full address (number, street and apartment, P.O. Box number)			
City		Province	Postal code
Telephone number	Fax number		

### 2 Case information

Last day worked (dd/mmm/yyyy)		
Is your condition due to an accident? <input type="radio"/> Yes <input type="radio"/> No <i>If "No," please go to item 3.</i>		
What kind of accident? <input type="radio"/> Motor vehicle accident <input type="radio"/> Work related <input type="radio"/> Other		
Name of Motor Vehicle Accident Insurance carrier	Contact person	Contact's telephone number
Describe how and when injury occurred		Date of accident (dd/mmm/yyyy)
		Time of accident <input type="radio"/> a.m. <input type="radio"/> p.m.
Is there any legal action involved? <input type="radio"/> Yes <input type="radio"/> No <i>If "Yes," please provide the following information:</i>		
Lawyer's name		Telephone number
Was the occurrence investigated by police? <input type="radio"/> Yes <input type="radio"/> No <i>If "Yes," please provide a copy of the police report.</i>		

### 3 Medical information

List all doctors consulted for your present condition.

Name of Doctor/Specialist		Approximately when did you first seek medical attention for this condition? (dd/mmm/yyyy)
Address of doctor (number and street)		Suite
		Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits
Postal code	Telephone number	Type of practitioner

**3 Medical information  
(continued)**

List all doctors consulted for your present condition.

Name of Doctor/Specialist		Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)		Suite	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	
<b>Diagnosis</b>			
Specific treatment plan (medications, treatments, etc.)			

**4 Work information**

What are your job duties?

When do you expect to return to your job?  Date (dd/mmm/yyyy)

**5 Certification, agreement and authorization**

**AMS : Agreement, Authorization & Certification for BC Colleges**

**I acknowledge** that my Employer has referred my case to Manulife Financial for the purpose of providing Abilities Management Access, and that Manulife Financial is not responsible for providing benefits in the event of a work absence.

**I certify** that the information provided by me in the course of Manulife Financial's involvement in my case, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.

**I authorize** any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, and any medically-related facility, rehabilitation provider, to release my personal information to Manulife Financial and/or its service providers for the purposes of the assessment, and management of my case, including independent medical assessments (the purposes being referred to herein, collectively, as the "Purposes"). **I authorize** Manulife Financial, and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the Purposes.

**I authorize** Manulife Financial to share and discuss with my Employer any functional limitations and restrictions that may impact my workplace accommodation(s) or my return to productive work.

**I authorize** the use of my SIN for the purposes of identification, if my SIN is used as my plan member certificate number. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original.

**I acknowledge** 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 and Privacy Information Package, available at [www.manulife.ca/groupbenefits](http://www.manulife.ca/groupbenefits), or from my Plan Sponsor.

**I understand** that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; 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.

Employee's signature	Date signed (dd/mmm/yyyy)
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