Manulife

BC Colleges, Universities and Institutes Benefits Consortium

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 and photocopies of file documentation.**

Please return the completed form to: **Manulife Case Management Centre**
1095 West Pender Street
PO BOX 48198
VANCOUVER BC V7X 1N8
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 policy number, and your employee certificate number from your employer.

Plan contract number	Employee certificate number	Division

Employer's name	Job title

Employee's full name (last, first, initial)	◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.

Date of birth (dd/mmm/yyyy)	Preferred language: ◯ English ◯ French	Height	Weight

Full address (number, street and apartment, PO Box number)

City	Province	Postal code

Telephone number ( )	Fax number ( )

2 Case information

Last day worked (dd/mmm/yyyy)

Is the current condition due to an accident? ◯ Yes ◯ No If *no*, please go to item 3.

What kind of accident?

◯ Motor vehicle accident ◯ Work related ◯ Other

Name of Motor Vehicle Accident Insurance carrier	Contact person	Contact's telephone number Ext. ( )

Describe how and when injury occurred	Date of accident (dd/mmm/yyyy)
	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 police? ◯ Yes ◯ No

If *yes*, please provide a copy of the police report.

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, street, suite)	Date of next visit (dd/mmm/yyyy)

City	Province	Frequency of visits

Postal code	Telephone number Ext. ( )	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, street, suite)		Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits
Postal code	Telephone number Ext. ( )	Type of practitioner

Diagnosis

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

I acknowledge that my Employer has referred my case to Manulife for the purpose of providing Abilities Management Access, and that Manulife 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'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 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, 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 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/planmember, or from my Plan Sponsor.

I understand 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 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; 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 name (please print)	
Employee's signature	Date signed (dd/mmm/yyyy)

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Group Benefits
Attending Physician's Statement
Abilities Management Access

The purpose of this Statement is to assist Manulife in confirming the anticipated duration of your patient's absence, determining functional abilities and assessing fitness to return to work. 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 CASE. ***PLEASE KEEP A COPY FOR YOUR RECORDS.***

Manulife recognizes and respects the role of the treating physician in the safe and timely return to work of their patients as outlined in the Canadian Medical Association Policy Statement.

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1 Patient authorization

Plan contract number	Employee certificate number	Division

Name of patient (last, first, middle initial)

Address (number, street and apt.)

Date of birth (dd/mmm/yyyy)	Height	Weight

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.**

Patient's signature	Date (dd/mmm/yyyy)

2 Attending Physician Statement

When did symptoms first appear or accident happen? — Date (dd/mmm/yyyy)

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

A. History

Has 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 worker's 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/mmm/yyyy)	Date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Date (dd/mmm/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) DSM IV Axis 1 (If psychiatric diagnosis)

What is the current GAF?

Remarks

e) **Please include copies of the following documentation in support of the stated diagnosis: consultation notes, test/investigation report(s), psychological testing report(s), operative report(s), hospital admission and discharge summary(ies).**

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

3 Treatment

Frequency of visits

Weekly

Monthly

Other (specify)

Date of first visit (dd/mmm/yyyy)

Date of last visit (dd/mmm/yyyy)

Date of all visits between first and last visit (dd/mmm/yyyy)

Nature of treatment (including surgery, physiotherapy, psychotherapy and medications prescribed and dosages)

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 licence be revoked? ◯ Yes ◯ No

4 Cardiac (if applicable)

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 any physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

5 Physician authorization

Attending physician (please print)

Certified specialist

Address (number, street, suite, city, province, postal code)

Telephone number ( ) Ext.

Fax number ( )

I certify 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. The information in this statement will be kept in a group life, health, and/or 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. By providing the information **I consent** to such unedited release of any information contained herein.

Signature

Date signed (dd/mmm/yyyy)

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