Manulife

Group Benefits Employee Declaration
Absence Management Consultation Services

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 and photocopies of file documentation.

Please send the completed form to:

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800, STN WATERLOO, Waterloo ON N2J 4C2
Tel: (416) 687-4100 or 1-877-277-5297 Fax: (416) 687-5155 or 1-877-329-4431
E-mail: casemanagement@manulife.com

1 Employee information

You can obtain your plan contract number and your employee ID number from your employer. Please fill in all information available. Missing information or incorrect information may result in a delay of claim processing.

Plan contract number 87090 Employer's name Toronto Dominion Bank

Employee ID number 7089057 Job title Insurance Sales and Credit Card Activation Specialist Language preference: (•) English ( ) French

Full name (first, middle initial, last) Joe-Ezigbo, Kenneth, E (•) Mr ( ) Mrs ( ) Ms

Date of birth (dd/mmm/yyyy) 08/JUL/1998 Height 6ft 2in Weight 185 KG Sex: Male

Street address (number, street, apt) 2951 Riverside Dr Apt 503

City Ottawa Province ON Postal code K1V8M6

Primary phone number (613) 4026769 Alternate phone number ( )

Work phone number Ext.

By providing my personal e-mail address, I am authorizing Manulife to use the address provided as an additional means of communication about my file.
I acknowledge that correspondence by e-mail may contain personal information including, but not limited to medical, employment and financial information.
I understand that my personal information is being sent in a manner that is not yet guaranteed as a secure means of communication.

E-mail address kenneth1284@hotmail.com

2 Case information

Last day worked (dd/mmm/yyyy) 19/OCT/2020

Is your condition due to an accident? If *no*, please go to section 3. ( ) Yes (•) No

If *yes*, what kind of accident? ( ) Motor vehicle accident ( ) Work related ( ) Other

Name of Motor Vehicle Accident insurance carrier

Contact person Contact's phone number ( )

Describe how and when accident 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 Phone number ( )

Was the accident investigated by police? ( ) Yes ( ) No If *yes*, please provide a copy of the police report.

3 Health care professional information

Please list all of the health care professionals you have consulted in the LAST 12 MONTHS, starting with the most recent, including family physicians, specialists, chiropractors, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name Dr. Chrizette Ang Type of practitioner General Practitioner

Complete address of health care professional (number, street, suite) 355 Adelaide St W, Unit 100

City Toronto Province ON Postal code M5V 1S2 Phone number (647) 4977453

Approximately when did you first seek medical attention for this condition? Date (dd/mmm/yyyy) 22/OCT/2020

Frequency of visits NA Date of next visit (dd/mmm/yyyy) NA

3 Health care professional information (continued)

Name: Audrey Ling

Type of practitioner: General Pracitioner

Complete address of health care professional (number, street, suite): 2600 CTTC Building - 1125 Colonel by drive

City: Ottawa Province: ON Postal code: K1S 5B6 Phone number: (613) 5206674

Approximately when did you first seek medical attention for this condition? Date (dd/mmm/yyyy): 26/10/2020

Frequency of visits: NA Date of next visit (dd/mmm/yyyy): NA

Name: Janet Still Type of practitioner: General Practitioner

Complete address of health care professional (number, street, suite): 2600 CTTC Building - 1125 Colonel by drive

City: Ottawa Province: ON Postal code: K1S 5B6 Phone number: (613) 5206674

Approximately when did you first seek medical attention for this condition? Date (dd/mmm/yyyy): 03/NOV/2020

Frequency of visits: NA Date of next visit (dd/mmm/yyyy): NA

4 Work information

What are your job duties?

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

5 Agreement, authorization and certification

Please print and sign this authorization and send to Manulife, using one of the following methods. If a printer is not available please contact your plan sponsor, or Manulife at 1-877-277-5297.

Via online claim submission:	Scan, save and attach it to your claim submission.
Via fax:	(416) 687-5155 or 1-877-329-4431
Via e-mail:	casemanagement@manulife.com
Via regular mail to:	Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON, N2J 4C2

I confirm:

- that my Employer has referred my case to Manulife for the purpose of providing Absence Management Consultation Services, and that Manulife is not responsible for providing benefits in relation to my current employment absence.
- 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:

- Manulife, its service providers, Manulife's reinsurers and its service providers, and any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer and administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my case, including independent medical assessments.
- Manulife to share and discuss with my Employer information regarding my functional limitations, restrictions and obstacles to return to work for the purpose of confirming the anticipated duration of my functional limitations and/or my workplace absence to assist in my return to productive work and **I acknowledge** that my medical information will not be provided to my employer unless my consent is explicitly obtained.

I confirm:

- that a photocopy or electronic version of this authorization shall be as valid as the original.
- I understand 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, available at www.manulife.ca/corporate/privacy-policy/canadian-division-privacy-policy.html or from my Employer.

I acknowledge:

- 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 or disclosure of 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 or authorized disclosure; 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.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife.

Employee signature:  Date (dd/mmm/yyyy): 03/NOV/2020

Employee name (please print): KENNETH JOE-EZIGBO

Please note: 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.

Manulife

CLHIA ACCAP

Group Benefits
Attending Physician's Statement
Absence Management Consultation Services

The purpose of this Statement is to assist Manulife in assessing your patient's fitness to perform their regular work duties.
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.
To avoid any delay in the processing of your patient's case, please fax, email, or mail the completed form to one of the following Manulife Case Management Centers (and keep a copy for your records).

Kitchener (English language)
casemanagement@manulife.com
Absence Management Consultation Services
PO BOX 800 STN C
KITCHENER ON N2G 4Y5
Tel: 1-877-277-5297
Fax: 1-877-329-4431

Montreal (French language)
gestiondesdossiers@manuvie.com
Absence Management Consultation Services
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-866-744-5741
Fax: 1-866-744-5742

1 Employee information and consent (To be completed by patient.)

Employee name (last, first, middle initial)	Home phone number ( )	Cell phone number ( )

Address (number, street, apt.)	City	Province	Postal code

Name of employer	Policy number	Employee number

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

Last date worked (dd/mmm/yyyy)	**Date returned to work or expected return to work date** (dd/mmm/yyyy)

I hereby authorize the release of any medical information in my file to the Manufacturers Life Insurance Company ("Manulife") for the purpose of assessing this claim related to my fitness to perform regular work duties. The medical information includes, but is not limited to copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it, my claim cannot be assessed. **I understand that I am responsible for any fees related to the completion of this form.**

Employee signature _____ Date (dd/mmm/yyyy) _____

2 Attending physician's statement

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the *last date worked,* complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary:

Secondary:

If childbirth provide expected or actual delivery date (dd/mmm/yyyy)
_____
Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☐

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☐ Date admitted (dd/mmm/yyyy): _____

Name of institution: _____ Date discharged (dd/mmm/yyyy): _____

If surgery was performed provide date and description of surgery.

Date (dd/mmm/yyyy): _____ Description: _____

Treatment (drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☐ | If Yes, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other _____

Attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit _____

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

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

In your opinion, is your patient competent to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life Insurance Company ("Manulife") and might be accessible by the patient 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.

Attending physician (please print)	Certified specialist		Physician's stamp
Address (number, street, suite)			
City	Province	Postal code	
Telephone number Ext. ( )	Fax number ( )		
Signature		Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

Manulife

CLHIA ACCAP

Attending Physician's Statement - Mental Health Conditions

Absence Management Consultation Services

The purpose of this Statement is to assist Manulife in assessing your patient's fitness to perform their regular work duties.
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.
To avoid any delay in the processing of your patient's case, please fax, email, or mail the completed form to one of the following Manulife Case Management Centers (and keep a copy for your records).

Kitchener (English language)
casemanagement@manulife.com
Absence Management Consultation Services
PO BOX 800 STN C
KITCHENER ON N2G 4Y5
Tel: 1-877-277-5297
Fax: 1-877-329-4431

Montreal (French language)
gestiondesdossiers@manuvie.com
Absence Management Consultation Services
PO BOX 400 STN PLACE-D'ARMES
MONTREAL QC H2Y 3H1
Tel: 1-866-744-5741
Fax: 1-866-744-5742

1 Employee information and consent (To be completed by patient.)

Employee name (last, first, middle initial)	Home phone number	Cell phone number
Joe-Ezigbo, Kenneth, E	( )	(613) 4026769

Address (number, street, apt.)	City	Province	Postal code
2951 Riverside Dr Apt 503	Ottawa	ON	K1V8M6

Name of employer	Policy number	Employee number
Toronto Dominion Bank	87090	7089057

Sex	Height	Weight	Date of birth (dd/mmm/yyyy)
☑ Male ☐ Female	6ft 2 in	185 KG	08/JUL/1998

Last date worked (dd/mmm/yyyy)	**Date returned to work or expected return to work date** (dd/mmm/yyyy)
19/OCT/2020	

I hereby authorize the release of any medical information in my file to the Manufacturers Life Insurance Company ("Manulife") for the purpose of assessing this claim related to my fitness to perform regular work duties. The medical information includes, but is not limited to copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it, my claim cannot be assessed. **I understand that I am responsible for any fees related to the completion of this form.**

Employee signature _____ Date (dd/mmm/yyyy) 03/NOV/2020

2 Attending Physician's Questionaire

I am the: Attending Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis
Primary:

Secondary:

Occupational illness/injury
Is this condition related to: ☐ Occupational Illness/injury ☐ Auto accident If yes, date of event: (dd/mmm/yyyy) _____

Details:

Date of first visit pertaining to this condition (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐
If yes, date: (dd/mmm/yyyy) _____ By whom: _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐
If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Patient's Description of Symptoms
Please describe the patient's current symptoms including frequency and severity:

Your Clinical Findings and Observations
Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy/Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration/Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐

Observations or comments supporting the above:

Complicating Factors
Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems
☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects
☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

Please describe the supports in place, or planned, to assist with these issues:

Investigations
Please attach copies of all relevant:
- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Are tests / investigations / consultations pending? Yes ☐ No ☐ Date report expected: (dd/mmm/yyyy) _____

Does the patient have an appointment booked with any specialist(s) in the near future? Yes ☐ No ☐

Name of Specialist	Specialty	Date of Appt: (dd/mmm/yyyy)
1. _____	_____	_____
2. _____	_____	_____

Reason for requesting the consultation:

Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐ Don't Know ☐

If yes, as of when? (dd/mmm/yyyy) _____ Type of licence: _____

Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mmm/yyyy)	Current dosage and date changed if applicable (dd/mmm/yyyy)	Response

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization anticipated? Yes ☐ No ☐

	Date admitted (dd/mmm/yyyy)	Date discharged (dd/mmm/yyyy)	Institution name
1.			
2.			

Treatment Details - Psychological
(e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mmm/yyyy)	Frequency of visits	Date of last visit (dd/mmm/yyyy)	Response
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		

Treatment Details - Concurrent Physiological Disorders, if known
(e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mmm/yyyy)	Frequency of visits	Date of last visit (dd/mmm/yyyy)	Response
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		
			Weekly ☐ Monthly ☐ Other ☐		

Overall Response to Treatment
Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐
Is the patient following the recommended treatment program? Yes ☐ No ☐
Please explain:

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐
If so, please explain:

Prognosis and Recovery
What return-to-work goals have been discussed with the patient? Please explain:

Please provide the patient's prognosis for improvement:
Please provide any other information that will help us understand the patient's current condition, recovery goals and prognosis:

3 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with the Manufacturers Life Insurance Company ("Manulife") and might be accessible by the patient 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.

Attending physician (please print)	Physician's Specialty		Physician's stamp
Address (number, street, suite)			
City	Province	Postal code	
Telephone number Ext. ( )	Fax number ( )		
Signature		Date signed (dd/mmm/yyyy)	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.