

Employee Statement

Short-Term Disability Claim

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for disability benefits under the Canada Post Short-Term Disability Program. A completed claim form must be returned within 14 days of the start of the disability to avoid interruptions in payments. The completed form should be mailed or faxed directly to:

MANULIFE FINANCIAL
2 QUEEN ST
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Telephone: 1-866-232-9674 or (613) 369-2000
Fax: 1-866-232-9642 or (613) 233-8233

*This form is not to be used for workplace injuries/illnesses.
 Ask your team leader instead to provide you with the appropriate WCB form.*

SECTION A Employee information (please print)

Employee name (Last, First, Middle initial):		<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.
Full address (Street, City, Province, Postal Code):		
Employee ID#	E-mail:	
Home phone #	Alternate phone #	
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):	

SECTION B Information about your work (please print)

Last day worked (dd/mm/yyyy):	<input type="checkbox"/> Full-Time	Team Leader's Name:
First day of absence (dd/mm/yyyy):	<input type="checkbox"/> Part-Time	
When do you expect to return to work:	<input type="checkbox"/> Term Employee greater than 6 months	Telephone #:
Job title:	Describe your job duties:	

SECTION C Information about your claim (please print)

Is your disability the result of: <input type="checkbox"/> non-work related illness? <input type="checkbox"/> non-work related accident? <input type="checkbox"/> motor vehicle accident?	
Describe your illness or injury:	
Have you had a similar or related condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how long ago (if applicable):	
Are you able to return to work on modified duties?	
Date and time of accident (If applicable):	Are you seeking reimbursement from a third party? <input type="checkbox"/> No <input type="checkbox"/> Yes
Briefly describe how and where the accident happened:	
Hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of Institution:
	Name of ward/unit:
Date admitted (dd/mm/yyyy):	Date discharged (dd/mm/yyyy):

SECTION D Income or benefit Information (please print)

Income / Benefit information		Start date	End date	Amount (indicate per week or monthly)
Have you applied for or are you receiving any of the following:	Employment Insurance			
	Benefits payable under any type of Worker's Compensation Board program (WCB / WSIB / CSST)			
	Benefits payable from Motor Vehicle Insurance or other insurance			
	Earnings from other employment			
	Other			
	<i>Note:</i> For the duration of your claim, it is your responsibility to notify Manulife Financial of any work performed, whether or not you have received any wage or remuneration; and any employment income paid to you as a result of work performed by you.			

Are you following the recommended treatment program? No Yes

Name of primary attending physician/Healthcare practitioner:

Specialty:

Date first treated:

Address:

Telephone #

Canada Post is subject to the Privacy Act and is committed to protecting employee personal information and managing this information with utmost responsibility and care.

You can be sure that any medical information you give to our disability-management providers will be kept strictly confidential and protected from improper and unauthorized use, disclosure, retention and disposal.

I certify that the information on this form is true and complete, to the best of my knowledge. I understand that my claim may be denied or terminated as a result of my providing false, or misleading information, or omitting pertinent information.

I authorize my doctor, Manulife Financial and its agents and service providers and any person or organization who has relevant personal information about me, including health professionals and organizations, to exchange information for the purpose of determining eligibility for and the adjudication of my claim. This includes the release of any related medical information, including but not limited to copies of all consultation reports, clinical notes, test results and hospital records.

I authorize Manulife Financial and Canada Post to exchange information about me except for details relating to diagnosis, treatment or medication relevant to this claim for the purpose of planning and managing my rehabilitation and return to work and for administration of the Short-Term Disability Plan.

I agree that a photocopy of this authorization shall be as valid as the original.

I agree to reimburse Canada Post for any Short-Term Disability plan overpayments.

Employee's signature:

Date (dd/mm/yyyy):