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Affinity Markets
Hospital and Home Care Plan Claim – Retired Women Teachers of Ontario

- This form should be completed by the claimant and the attending physician when making a claim for an illness or injury. You can help us to expedite the handling of your claim by making sure that all questions are answered and by attaching all original receipts or itemized statements for which you are claiming benefits.
- Incomplete claim forms will be returned for completion.
- Please allow 10-15 days for your claim to be processed.
- Send the completed original claim form and all other required documents to:

Manulife Financial
Affinity Markets Health and Dental Claims
P O Box 670 Stn,Waterloo
Waterloo, N2J 4B8.

Section 1 - Claimant's Statement

1 Personal information

Primary Insured Person's name (last, first, initial) — Date of birth (dd/mmm/yyyy)

Claimant's name (last, first, initial) — Date of birth (dd/mmm/yyyy)

Relationship to Primary Insured Person

Claimant's address (number, street and apt. number)

City — Province — Postal code

Plan number: 17777C — Identification number — Claimant's residence telephone number ( )

2 Details

My claim is the result of ◯ Accident ◯ Illness ◯ Injury

Describe the accident (give specific details on when and how the accident occurred)

Date of accident/initial onset of illness (dd/mmm/yyyy) — Date of initial medical consultation (dd/mmm/yyyy)

Full details

Describe the illness/injury

Details of hospital visit

After discharge from hospital, on what date did you resume your normal daily outdoor activities (ie. shopping, visiting, etc)? — Date (dd/mmm/yyyy)

If you are still confined to your home, when do you expect to resume your daily outdoor activities? — Date (dd/mmm/yyyy)

Have you ever had this or a similar condition in the past? ◯ Yes ◯ No

If yes, please confirm date and name of attending physician.

Indicate which of the following benefits you are claiming.

◯ Convalescence indemnity (following hospitalization) — From (dd/mmm/yyyy) — To (dd/mmm/yyyy)

◯ Convalescence indemnity (following outpatient surgery) — From (dd/mmm/yyyy) — To (dd/mmm/yyyy)

◯ Fracture indemnity (specify which bones)

◯ Home nursing benefit (receipts required)

◯ Transportation benefit (to and from hospital or doctor's office; receipts or itemized statement required)

◯ Comfort care benefits (during hospitalization; no receipts required)

◯ Ambulance/taxi benefit/private ambulance (receipts required)

Details of hospital visit (*continued*)

Please attach original receipts or itemized accounts.

- ◯ Assistive devices benefit (receipts required)
- ◯ Physician validation expense (receipts required)
- ◯ Physiotherapy benefit (receipts required)
- ◯ Special equipment benefit (receipts required)
- ◯ Cataract surgery benefit (receipts required)
- ◯ Other (please specify)

Details of doctor consulted

Family physician's name

Telephone number

( )

Address (number, street, and suite number)

City

Province

Postal code

3 Signature and date

I hereby certify that the above statements are true and accurate to the best of my knowledge and belief.

Claimant's signature

Date signed (dd/mmm/yyyy)

4 Authorization

I certify that the information in this form, and any further written statement provided by me in the future, is true and complete to the best of my knowledge. **I agree** that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I authorize 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, administrators of government benefits or other benefit programs, the Medical Information Bureau **(MIB)** and investigative agency, to release my personal information to Manulife Financial and/or its service providers for the purposes of the Retired Women Teachers of Ontario **(RWTO)** Hospital and Home Care plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I authorize Manulife Financial, its reinsurers 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 of the Retired Women Teachers of Ontario **(RWTO)** Hospital and Home Care plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

Primary Insured Person's name (last, first, initial) (please print)

Claimant's signature (if under the age of 16, the Primary Insured Person must sign)

Date signed (dd/mmm/yyyy)

Witness's signature

Date signed (dd/mmm/yyyy)

5 Statement of confidentiality

The specific and detailed information requested on the hospital and home care plan claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife Financial) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, PO BOX 4213, STN A, TORONTO ON M5W 5M3. A copy of our privacy principles and practices is available for view at **manulife.ca**.

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• ***Attending physician must complete all sections in full.***

Section 2 - Attending Physician's Statement

1 Patient information

Patient's name (last, first, initial)

Date of birth (dd/mmm/yyyy)

2 Details of injury/ impairment

Nature of injury/impairment

First attendance date (dd/mmm/yyyy)

Actual injury/impairment date (dd/mmm/yyyy)

Date of surgery (dd/mmm/yyyy)

Details of surgery

Is the injury/impairment permanent and irrecoverable?

◯ Yes ◯ No

Give extent of loss/impairment

Claimant will be totally disabled:

From (dd/mmm/yyyy)

To (dd/mmm/yyyy)

Please describe restrictions and limitations due to impairment

Who provided initial care? If you did, what evidence of trauma did you find?

Did any disease or previous injury contribute to the loss/impairment?

◯ Yes ◯ No

If yes, please describe

Has patient ever had the same or similar condition?

◯ Yes ◯ No

If yes, please state when and describe

List names and addresses of other physicians or surgeons, if any, who attended the claimant

Name

Address (number, street, and suite number)

City | Province | Postal code

Name

Address (number, street, and suite number)

City | Province | Postal code

Name

Address (number, street, and suite number)

City | Province | Postal code

3 Hospital admission details

Date of hospital admission (dd/mmm/yyyy)

Date of hospital discharge (dd/mmm/yyyy)

Indicate the type of hospital admission

◯ Acute Care Unit ◯ Intensive Care Unit ◯ Rehabilitation Care Unit
◯ Critical Care Unit ◯ Out-patient ◯ Other

If other, specify area

Indicate date of transfer, if applicable

Date of transfer (dd/mmm/yyyy) Actual injury/impairment date (dd/mmm/yyyy)

Hospital address

4 Current medical care

Are you actively treating the patient? ◯ Yes ◯ No

Date of last consultation (dd/mmm/yyyy)

Indicate type of treatment including medications

Frequency of visits

◯ Weekly ◯ Other If other, specify
◯ Monthly

Attending physician's name

Specialty

Address (number, street and suite number)

City

Province

Postal code

Telephone number
( )

Fax number
( )

Signature of physician

Date signed (dd/mmm/yyyy)

Fee: The patient is responsible for securing this form and for charges made for its completion.