Manulife

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 5 days for your claim to be processed.
- Send the completed original claim form and all other required documents to:
  Manulife
  Affinity Markets Health and Dental Claims
  P.O. Box 670, Stn Waterloo
  Waterloo, ON 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

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

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

Describe the illness/injury

Full details

Details of hospital visit

After discharge from hospital, on what date did you resume your normal daily outdoor activities (i.e. 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 Ext. ( )
Address (number, street, and suite number)	
City / Province / Postal Code	

3 Authorization

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:
I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim submission. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers, for the purposes of plan administration, audit and the assessment, investigation and management of this claim (Purposes). **I agree** that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

I agree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the plan with Manulife, and **I authorize** Manulife to deduct such monies from my future claims. **I agree** a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Manulife's Privacy Policy is available at manulife.ca.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a financial services file. Access to my 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.

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)

4 Statement of confidentiality

The specific and detailed information requested on the Hospital and Home Care Plan Claim form is required to process the application. To protect the confidentiality of this information, Manulife 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 employees, mandataries, 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 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: Chief Privacy Officer, Manulife, P.O. Box 1602, Del Stn 500-4-A Waterloo, Ontario N2J 4C6. A copy of our privacy policy is available on **manulife.ca**.

5 Accessibility statement

Manulife is committed to offering products and services to persons with disabilities, in ways that are consistent with the principles of dignity, independence, integration and equal opportunity. Manulife has a core belief that everyone should be treated with courtesy and respect and made to feel welcome. Manulife's accessibility policy allows you to receive this form in alternate formats upon request. Please contact us at accessibility@manulife.com, or call us at 1-855-891-8671, if you would prefer this document in an alternate format. If you would like more details about accessibility at Manulife, we would encourage you to visit our website at **manulife.com/accessibility**.

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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 ◯ Monthly

If *other*, specify

Attending physician's name

Specialty

Address (number, street and suite number)

City

Province

Postal code

Telephone number Ext.

( )

Fax number

( )

Signature of physician

Date signed (dd/mmm/yyyy)

PRINT

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

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