Manulife™

Disability Guide

The City of Whitehorse

Policy: 0126487 (STDAS), 0126236 (LTD), 0126823 (SAWS)

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ACRONYMS, ABBREVIATIONS AND DEFINITIONS

Plan Sponsor (PS):	The plan sponsor is the party sponsoring the disability insurance contract. This party can be an employer, union, or a trustee group.
Plan Administrator (PA):	Plan sponsor contact person
Plan Member (PM):	Insured individuals under the disability plan are referred to as plan members.
Attending Physician's Statement (APS):	Attending Physician's Statement
Initial Rehabilitation Assessment (IRA):	Initial Rehabilitation Assessment
Return To Work (RTW):	Return to work
Short Term Disability (STDAS):	Short Term Disability Adjudication Services
Long Term Disability (LTD):	Long Term Disability
Change of Definition (COD):	**Change of Definition** is a point in the claim (usually 24 months after the end of the LTD qualifying period) when the definition of disability changes from "own occupation" to "any occupation".
Qualifying Period:	A period of continuous total disability, starting with the first day of total disability, which must be completed by the employee in order to qualify for benefits.

ROLES WITHIN MANULIFE

Senior Disability Administrator:	Involved in the setup of claims, clarifies coverage information and confirms salary, benefit and date information. Follow up with PM, PA and doctors for outstanding information.
Case Manager (CM):	Analyses and adjudicates disability claims taking into account contractual, medical, occupational and functional information. Develops a case management plan and communicates with all parties on all claims issues.
Disability Specialist:	Contact person for escalations and appeals, and assists CM with complex case management.
Functional Rehab Specialist:	Develops, monitors and implements innovative functionally orientated rehabilitation plans for PM. May be involved in contact/meeting with PA, PM, physicians and other health care professionals to implement RTW plan.
Vocational Rehab Specialist:	Develops vocational rehabilitation plan with a goal for RTW to an alternate occupation for PM not able to RTW to their own occupation.

Return to Work Facilitation Specialist:	Facilitates contact/meeting between PA and PM to clarify limitations and expectations for a timely and successful RTW.
Mental Health Specialist:	Develops and implements education, training, and best practices around the management of mental health disabilities. Conducts file reviews and works with the Absence & Disability Case Managers at set milestones throughout the life of a mental health claim to guide the management and ensure appropriate treatment and support is provided.
Associate Manager:	Provides leadership to disability teams and is responsible for workflow management and service performance.
Disability Management Consultant:	Provides consulting services to improve claims incidence and costs. Collaborates with regional group office teams to identify challenging issues in order to assist with claims experience.

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Short Term Disability Adjudication Services (STDAS)

About this service

What are Short Term Disability Adjudication Services (STDAS)?

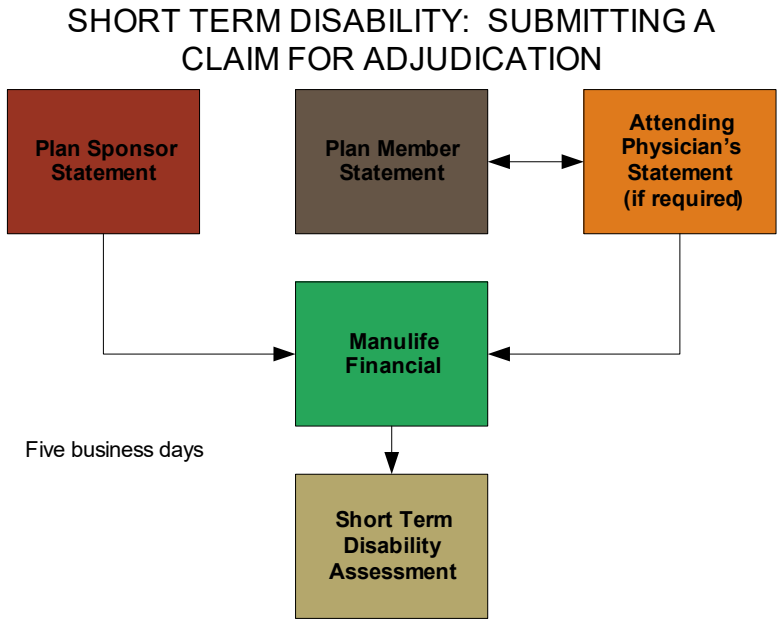
Short Term Disability (STD) benefits provide an eligible plan member with weekly income replacement for a limited period of time should an illness or injury occur while they're insured, and cause them to become unable to work. Although your company administers the payment of STD benefits for your employees, you have contracted with Manulife to adjudicate STD claims on your behalf. These services are provided according to the terms of your **Plan Contract**.

With STDAS, our focus is working in partnership with you, your front-line managers, supervisors or leaders and the employee to help your plan member make a safe, timely and effective transition back into the workplace.

Submitting a Claim for Adjudication

How does the application process for STDAS adjudication work?

Submitting an STD claim for adjudication starts with three forms - the **Plan Sponsor Statement**, **Plan Member Statement** and the **Attending Physician's Statement**. It is important that all STD claim forms are completed correctly. Missing or incorrect information can result in delays. The case manager or senior disability administrator (who supports the case manager) will follow-up with the plan administrator for any outstanding forms after 3-15-20 business days. Once all three forms have been completed and received by Manulife, we can begin assessing the claim.



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What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Provide the **Plan Member Statement** and the **Attending Physician's Statement** to the plan member. You'll find all the documents you need on the forms section of the Plan Administrator secure site. • Complete and submit the **Plan Sponsor Statement** to Manulife. Where possible, please have the direct supervisor complete and sign the *Work information* section of the form. If a *Job Demands Analysis* is available, please include this information along with your form. Please see the Forms section of this guide if you require assistance with completing the **Plan Sponsor Statement**. • Stay in contact with the plan member once they leave work to provide support and preserve their connection with the workplace. • Follow up periodically to ensure that any outstanding forms or information have been submitted to Manulife.
Plan member	• Complete and submit the **Plan Member Statement** to Manulife by fax or mail, ensuring the consent and authorization is signed and dated. • Sign and date the *Patient Authorization* on the **Attending Physician's Statement** before taking it to their doctor to complete. • Pay any fees associated with completing the **Attending Physician's Statement** and ensure the completed form is submitted to Manulife. • Follow the instructions provided for the appropriate care and treatment of the condition. • Let the plan administrator know when they are capable of returning to work with full or modified duties. • When possible, stay in contact with their direct supervisor, manager or plan administrator.
Attending physician	• Complete the **Attending Physician's Statement**, including any relevant documentation, clinical findings, restrictions and limitations, consultation reports, test results and chart notes. • Return the completed forms to the plan member or submit the required documents to Manulife by fax or mail.
STD case manager	• Assess the STD claim within five business days, once all forms have been received by Manulife. • Advise the plan administrator after 3-15-20 business days if there are any outstanding forms required to complete the assessment of the claim.
Senior disability administrator	• May support the STD case manager by following up for missing forms after 3-15-20 business days. • If forms are missing, send notification to the plan administrator advising that the claim cannot be assessed until all forms have been received.

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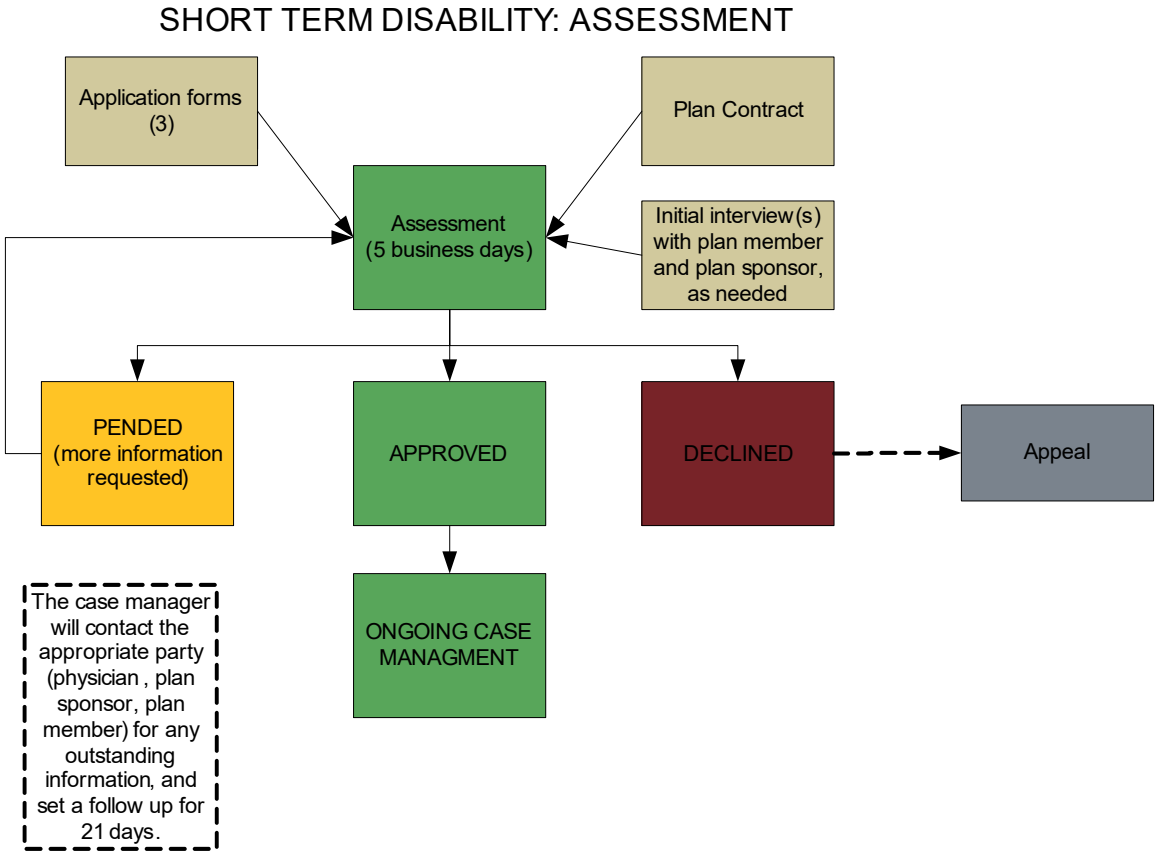
Assessment

How does assessment of a STD claim work?

Once we have received the full claim package, the case manager can begin reviewing the STD claim, the contract and, when needed, conducting interviews with the plan administrator and plan member to help ensure that everyone has a clear understanding of all aspects of the claim.

If we have all the information we need, assessment of a STD claim should take about five business days. Both you and the plan member will be notified when the absence is supported, declined or pended (until additional information can be provided).



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What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Provide details about the plan member's essential duties, work environment, and any work-related issues to the case manager. • Participate in telephone interviews with the case manager, if required. • Advise the case manager and plan member if modified work duties or accommodations are available and ensure they are implemented safely. • Administer payment of the STD benefits.
Plan member	• Participate in the initial telephone interview with the case manager, if requested. • Provide any additional information or documentation that may be required by the case manager to complete the assessment of the claim.
Attending physician	• Diagnose and treat the patient's medical condition. • Provide any additional information as requested by the case manager. • Charge the reasonable and customary fees for providing the information requested.
STD case manager	• Review the relevant terms of your contract, claim forms, and other documents submitted as part of the STD claim application. • Work with the plan member, plan administrator and attending physician to identify opportunities or modifications to support a safe and timely return to work. • If required, conduct telephone interviews with the plan administrator and/or plan member to clarify claim details, work duties, functional abilities, salary information, and any return to work barriers. • Provide a decision on the STD claims application within five business days of receiving the completed claims forms.

How will I find out if the absence is supported?

Once all required STD forms have been received by Manulife, you can expect to receive a decision about the absence within five business days.

If I'm the:	I will receive:
Plan administrator	• Notification (by email or letter) from the case manager if the absence is supported, denied or pended (awaiting further information to complete the assessment).
Plan member	**If the absence is...** • **Supported** - The case manager sends a statement or decision letter indicating that we support the disability up to a specific date or event. • **Declined** - The case manager issues a decision letter providing detailed information about our assessment of the absence and the rationale behind the decision. Instructions for making an appeal are also provided, unless the decision was made for contractual reasons. • **Pended** - The case manager will send a pended letter outlining any additional information that may be required in order to complete the assessment of the STD claim.

Case Management

How does the case management process work?

Once an STD claim is approved, ongoing case management begins.

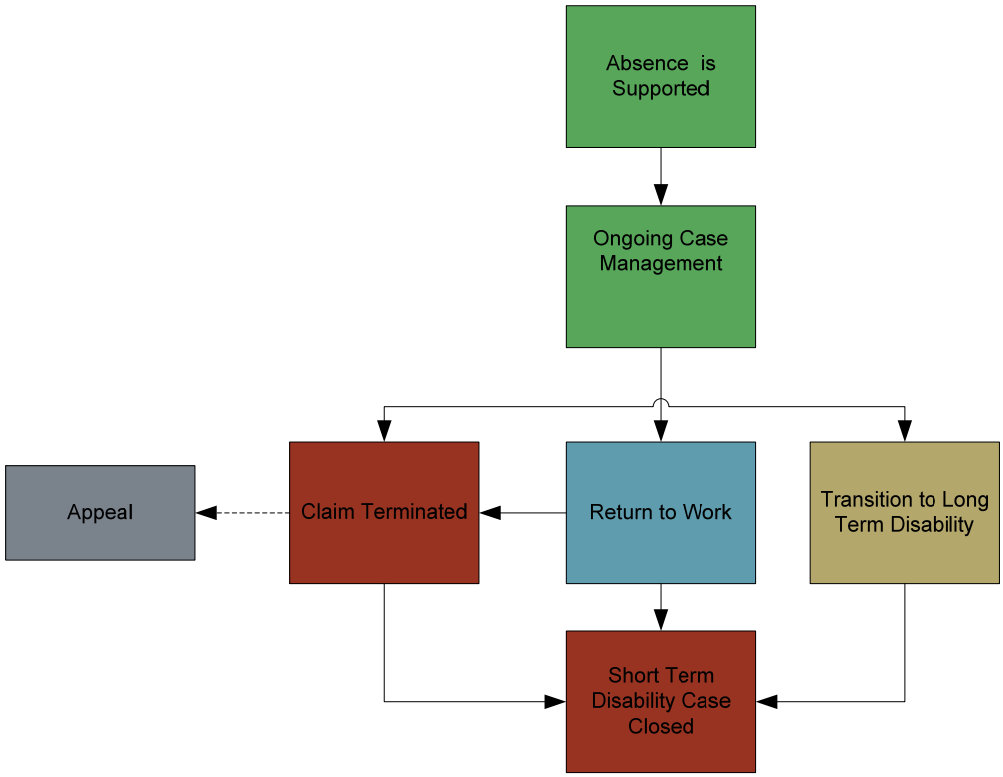
Our evidence-based disability claim review process provides timely fair decisions to all plan members. For Short Term Disability (STD), we start by triaging claims based on complexity.

The majority of STD claims are straightforward, with a return to work date that is clear, timely and reasonable for the diagnosis. The STD case manager adjudicates these claims using industry standard medical duration guidelines to determine a reasonable period of disability. If the total time off work is reasonable taking into consideration the diagnosis, occupational demands, plan member's age, and other factors, then the absence is approved according to the duration established by the guidelines. Approval of the absence beyond these guidelines is contingent upon medically supported complications and restrictions as documented by a physician.

There are some claims that exceed the standard medical duration guidelines, or that have additional medical or non-medical influencing factors (e.g., workplace concerns, social or relationship issues) impacting the plan member's recovery. In these situations, the case manager may access a number of additional resources to facilitate the plan member's recovery and transition back to the workplace. These resources could include a functional phone interview with the plan member, a phone interview their supervisor, a referral with a Manulife medical consultant or specialist, or a referral to rehabilitation consultant. If the recovery is going to be prolonged and the LTD benefits are with Manulife, the STD case manager will work closely with the LTD case manager to ensure a smooth transition to LTD.

Regardless of the type of claim, the case manager will continue providing communication and support until the plan member makes a timely, safe and sustainable return to work, transitions to Long Term Disability benefits or the claim is closed.

SHORT TERM DISABILITY: ONGOING CASE MANAGEMENT



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What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Maintain contact with the plan member to provide support and preserve their connection with the workplace. • Work with the case manager to identify opportunities for modified duties or accommodations that would support a safe, timely, and sustainable return to work. • Share information with our case managers and rehabilitation specialists regarding the plan member's ability to perform the work prior to the absence/disability, the anticipated barriers (if any) on return, and any other information such as non-medical work related barriers. • Administer payment of the STD benefits.
Plan member	• Stay in touch with the case manager, as requested, and provide updates should their medical status change. • Stay in touch with their plan administrator/supervisor and inform them of their progress and readiness for return to work. • Actively participate in the evidence-based treatment recommendations as outlined by their health care providers. • Work with the case manager and plan administrator to identify opportunities for modified duties or accommodations that would support a safe, timely, and sustainable return to work. • Provide any additional information requested by the case manager, including medical information and follow up with the physician to ensure the information has been sent.
Attending physician	• Provide medical support and recommendations to promote an active recovery. • Provide any additional medical information to Manulife or the plan member when requested by the case manager. This may include completing the **Attending Physician's Update**. • Work with the case manager, plan administrator, and plan member to identify functional abilities and opportunities for modified duties or accommodations that would support a safe, timely, and sustainable return to work.
STD case manager	• Request any additional information that may be required based on their assessment of the claim. • Follow-up with the plan member for any medical information still outstanding 21 days after the initial request and provide notification if benefits may be suspended. • Review any new medical information within five business days of receipt. • Work with the attending physician, plan administrator, and plan member to identify opportunities for modified duties or accommodations that would support a safe, timely, and supportive return to work. • Access the support and resources needed to actively manage the claim in a timely manner (e.g. Manulife's consulting physicians, mental health specialists, rehabilitation services, independent medical evaluations, etc.). • Communicate the expected duration of the absence, return to work date and/or ongoing case management plan to the plan administrator and plan member.

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Return to Work / Rehabilitation

What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Review the Return to Work Guide for Managers for information to help support your employee's return to the workplace and ensure the direct supervisor also has a copy. • Prepare for the plan member's return to work and offer accommodations such as modified hours, duties or work environment. • Review the return to work plan with the plan member. • Provide confirmation of the number of hours worked. • Request additional support from the case manager or rehabilitation specialist when required.
Plan member	• Review the Return to Work Guide for Employees to help prepare for your return to the workplace. • Review the return to work plan with the plan administrator, direct manager or supervisor before returning to the workplace. • Establish regular meetings with the direct supervisor or manager as required. • Participate in any medical treatment required to support the return to work plan. • Seek medical attention immediately if symptoms reoccur or increase during return to work process. • Contact the case manager with any questions or concerns throughout the return to work process.
Attending physician	• Provide medical support and recommendations to promote an active recovery. • Provide any additional medical information to Manulife or the plan member when requested by the case manager. This may include signing a return to work proposal. • Work with the case manager, plan administrator, and plan member to identify opportunities for modified duties or accommodations that would support a safe, timely, and effective return to work.
STD case manager	• Access the support and resources needed to actively manage the STD claim in a timely manner (e.g., Manulife's medical consultants, rehabilitation services, independent medical evaluations). • Work with the plan administrator, plan member, attending physician, and our rehabilitation specialist to find the best solutions for the return to work plan. • Address any questions or concerns throughout the return to work process.
Rehabilitation specialist	• If involved, work with plan administrator, plan member, and case manager to find the best solutions for the return to work plan. • Address any questions or concerns throughout the return to work process.

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Transition to Long Term Disability

When should the transition from STD to LTD start?

The STD case manager will start the transition from STD to LTD about eight weeks before the STD Maximum Benefit Period has been reached. Because we have managed your employee's absence during the STD period and your LTD coverage is with Manulife, we have simplified the transition process. We will not require the initial **LTD Attending Physician's Statement**, and we have condensed our **LTD Plan Sponsor Statement** to reduce your administrative burden.

What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Complete and submit the condensed **Long Term Disability Plan Sponsor Statement** to Manulife as requested by the case manager.
Plan member	• Continue to work with the case manager and provide any requested forms, such as an up-dated authorization and direct deposit information.
Attending physician	• If required, provide additional medical information in support of both the STDAS and potential LTD claims.
STD case manager	• Initiate a review of the claim with the LTD case manager about eight weeks prior the STD Maximum Benefit Period. • Ask the plan administrator to complete the condensed Plan Sponsor Statement and follow-up within five business days for any outstanding forms. • Ask the plan member to complete and return any necessary forms. • Request any additional medical information required for the assessment of the LTD claim. • Work with plan administrator, plan member and LTD case manager to ensure a smooth transition from STD to LTD benefits.
Manulife LTD case manager	• Identify any additional medical information that will be required for assessment of the LTD Claim. • Work with the STD case manager to ensure a smooth transition from STD to LTD benefits.

Appeals

How does the appeals process work?

At Manulife, we believe employees should be offered the option to appeal when their case is not supported for medical reasons. An appeal is a written request from the employee that asks Manulife to revisit the decision on their medically declined file.

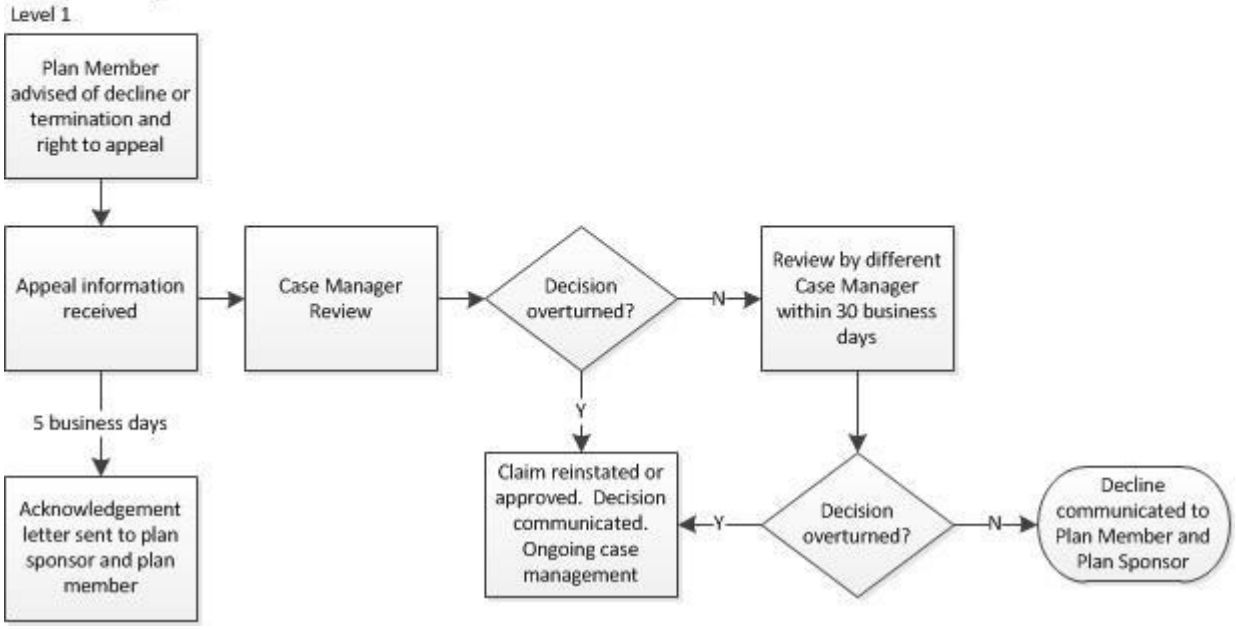
When a plan member appeals an STD claims decision, a different case manager or appeals specialist will manage the file. There are three levels of appeals, each requiring that new unreviewed medical evidence is provided. We seek to reach decisions or provide updates on appeals within 30 calendar days.

Employees are encouraged to file their appeal in writing within 30 days of receiving the decision letter. Employees are advised that Manulife will not consider or review any appeals which are submitted after a set date. The date is the later of 12 months from the date benefits cease or 12 months from the date of the decline or termination letter. This date does not change during the course of the appeal process.

The appeal process is exhausted on the earlier of the completion of the third level of appeal or the 12 months period from the date of declination or termination.

STDAS Appeal Process

Appeal information must be submitted within 30 days of the date of the decline/termination letter. Manulife Financial will not consider/review any appeals which are submitted greater than 12 months from the date benefits ceased or the date of the decline/termination letter – whichever is greater.



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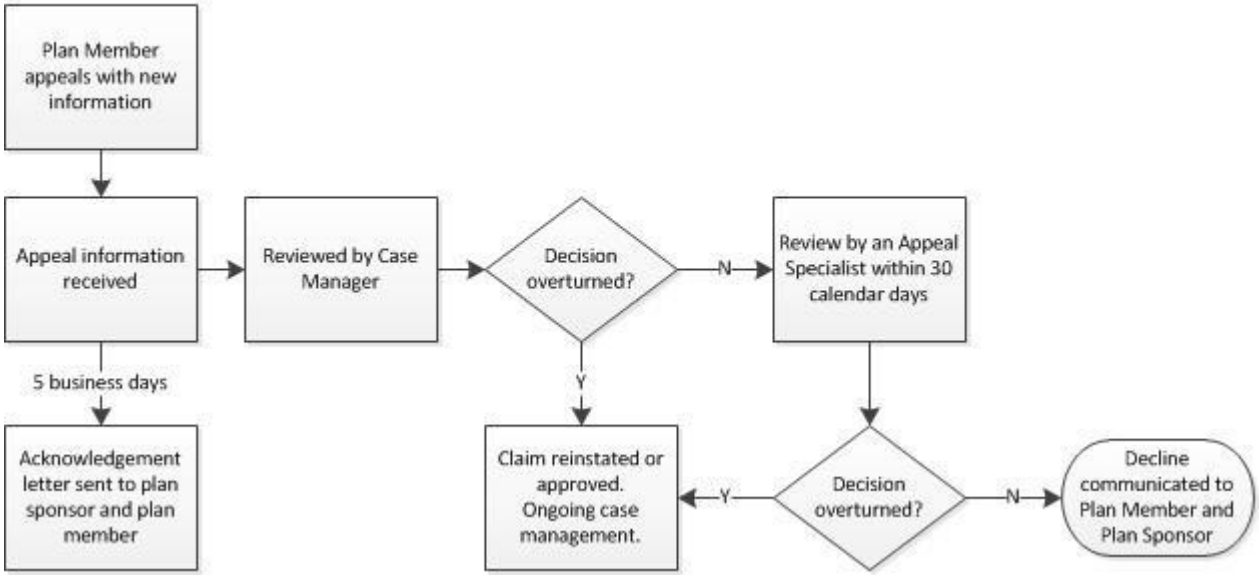
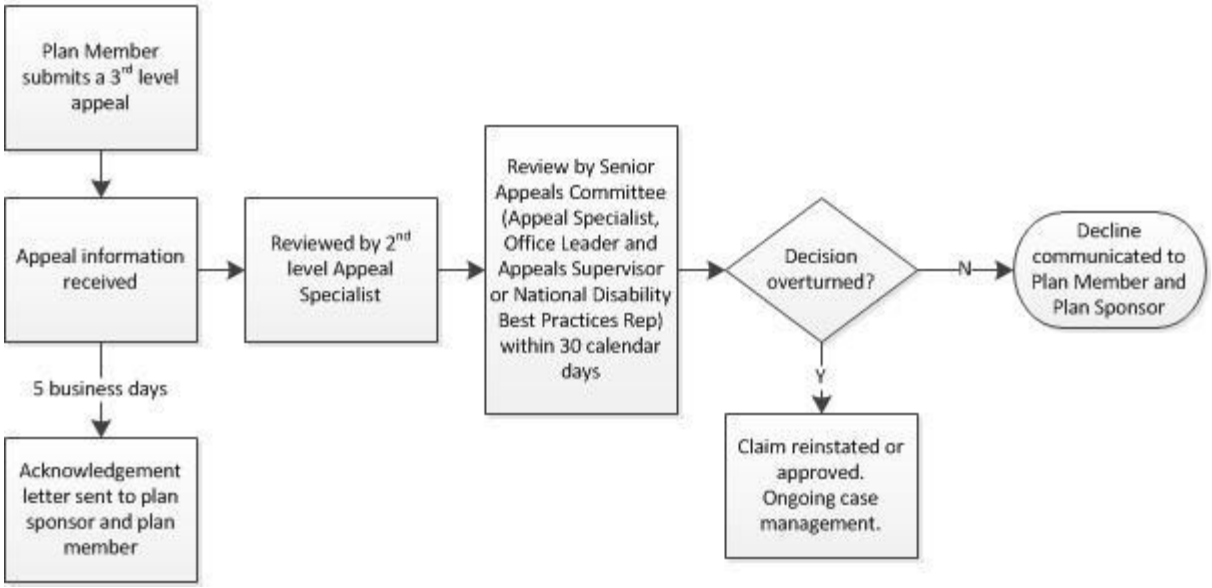
Level 2



Level 3



What's my role?

When it comes to STDAS, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Direct any questions about the appeals process to the case manager.
Plan member	• Notify Manulife in writing, within 30 days from the date of the decision letter if they wish to appeal. • Notification should include the reason(s) why they disagree with the decision, as well as any additional medical information or evidence they have to support their position. The plan member should review the decision letter with their attending physician to determine the type of information that may be needed to support their appeal. • Complete the **Plan Member Authorization to Share Information** form if requested by the case manager.
Attending physician	• Provide any additional information in relation to the appeal.
Manulife STD case manager	• Acknowledge receipt of an appeal within five business days. • Review appeal information. If decline decision is maintained, refer claim to appeal specialist. If claim is reinstated or approved, communicate decision to plan member and plan sponsor.
Manulife appeals specialist	• Conduct an initial review within 10 business days to determine if further information or investigation will be required to complete the appeals process. • Gather the required information or conduct any further investigation (e.g., medical, vocational) needed to complete the appeal. • Engage additional resources and support as required (e.g., Manulife Claims Director, Manulife's consulting physicians and affiliated Manulife Disability Best Practices Specialists). • Provide a decision or status update on the appeal within 30 days from the date it was received.

How will I find out about an appeals decision?

You can expect to receive acknowledgement of a plan member's intent to appeal an STD claims decision within five business days of its receipt, in writing, by the case manager. The case manager or appeals specialist will provide written notification of the decision or status update within 30 days.

If I'm the:	I will receive:
Plan administrator	• Acknowledgement of the plan member's intent to appeal within five business days of receipt. • Notification of the decision (reinstated or maintained) within 30 days.
Plan member	• Acknowledgement letter sent by the case manager or appeals specialist confirming receipt of the plan member's intent to appeal - within five business days of receipt. • Letter of decision notification sent by the case manager or appeals specialist within 30 days. **If the decision on the claim has been...** ○ **Reversed** - The case manager or appeals specialist sends a decision letter advising the claim has been reinstated and will return to ongoing case management. ○ **Maintained** - The case manager or appeals specialist issues a decision letter providing detailed information about the assessment of the appeal and the rationale for the decision.

Forms

Where can I find STDAS claim forms?

You'll find all the documents you need to submit a claim for STD claim adjudication in the forms section of the Plan Administrator Secure Site:

- Plan Sponsor Statement;
- STDAS Member Statement;
- Attending Physician's Statement;
- Attending Physician's Update; and the
- STD Plan Member Benefits Guide.

Guide to completing STDAS claim forms

When it comes to STD claim adjudication, we need to gather information from you, the plan member, and the plan member's physician(s) in order to assess the absence. We're unable to begin reviewing a claim until each of the forms have been completed and submitted to Manulife.

Be sure to include the plan member's plan information and where possible, have the plan member's direct supervisor complete and sign the *Work information* section of the **Plan Sponsor Statement**. An incomplete form may result in delays in the adjudication of the plan member's absence, so please take a moment to ensure that nothing has been overlooked and follow up to ensure that all forms have been submitted.

Please refer to the sample claims form for assistance completing the **Plan Sponsor Statement**.

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Frequently Asked Questions

How do I know what dates to pay from and to for the plan member's absence?

You will be notified by the case manager as to the approval start and end date. We will notify you of the end date when an absence is no longer supported. If a claim appeal decision is reversed, we will notify you as to the date the absence is supported from. You can align your payroll accordingly.

How do you determine the essential duties of a plan member's occupation?

Essential duties are usually:

- those required to perform the occupation
- those that cannot be reasonably omitted or modified
- those that are fundamental to the occupation
- those done at a frequency and/or duration that cannot be omitted

In determining the essential duties of the occupation, the case manager will review the job description and duties outlined on the plan sponsor and plan member forms. The case manager may also contact the plan member and/or plan sponsor to review the job description and clarify essential duties.

Do I need to submit a disability claim if the plan member is working modified duties?

A request for modified work must be medically supported. In most cases, accommodations should be temporary with a progression towards full time hours and duties. If the plan member's earnings are not impacted and the modification is for a short duration, you may not need to submit a claim. However, if you are in doubt, or there are further requests to extend the modified duties beyond the midpoint of the STD benefit period, a claim should be submitted.

If a plan member is on a WSIB/WCB claim, do I need to notify Manulife?

For plan members with LTD and Life Waiver of premiums (LW), we recommend initiation of the LTD application within eight weeks of the end of the LTD qualifying period.

In the event the WSIB/WCB claim closes for reasons not related to recovery and return to work own occupation, (e.g., due to the onset of another condition for which WSIB/WCB is not payable), the LTD claim is already established and Manulife can proceed with assessment of eligibility. This eliminates the potential for delays associated with late notification and/or filing of proof of claim. Please note, the assessment of disability starts on the date the plan member was injured or absent from work due to a work related incident.

What happens if a plan member becomes disabled while on strike or an indefinite layoff?

Disability coverage ceases as of the last day Actively at Work. If a plan member becomes disabled during the strike or indefinite layoff, the plan member is ineligible to claim for disability benefits.

What happens if a plan member becomes disabled while on maternity or parental leave, or while on a temporary layoff or leave of absence?

The handling is dependent upon whether disability coverage is available and is continued during the specific form of leave of absence or temporary layoff.

Under our standard contract wording,

- For maternity and parental leaves, disability coverage can be continued during the period of leave to which the plan member is entitled by legislation governing the plan sponsor.
- For temporary layoff and other leaves of absence, disability coverage can be continued at the plan sponsor's election to a maximum period of 120 days from the date the plan member was last actively at work.

Coverage continuations for other durations may be considered by Manulife on a case by case basis. Manulife must be advised and approve of any exceptions in advance.

If disability coverage is continued and a plan member becomes disabled during the leave of absence or temporary layoff, the qualifying period starts as of the date of disability and benefits become payable on the later of the date the qualifying period is satisfied, or the date the plan member is scheduled to return to work.

If an employee is off on disability, when should they stop paying STD and LTD premiums?

If the plan member applies for LTD benefits with Manulife, premiums should only be discontinued when Manulife approves the waiver of premiums on LTD and/or Life benefits.

For waiver of premiums on Life and LTD benefit coverage, the Waiver begins on the next premium due date coincident with or following the approval date of the LTD or Life Waiver Claim.

If your account/policy is administered through Head Office, the premium adjustments will flow through upon acceptance of the claim. If your account/policy is self-administered, reconciliation can occur once you receive confirmation of claim approval.

What do I need to do if a member's claim is terminated?

Please refer to the plan administrator responsibilities sections of this guide for the various claim termination/decline situations. In general, if a claim has been declined or terminated, you should be contacting your plan member to discuss whether they will be appealing Manulife's decision to decline or terminate their claim. If the plan member is not appealing our decision, you should discuss return to work options with them as per your internal policies and procedures.

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Important Information

Protecting plan member privacy

Protecting the privacy of our plan members is at the forefront of everything we do. We can only communicate confidential claims information if we have a signed authorization from the plan member. See our privacy policy for details about the information.

What information can we provide to you?

We are able to share administrative and payment information with you, including claim status, the amount of benefit payment, amounts paid by any employer or other source that may be offset from the benefit payment (e.g., CPP disability payments). While we are not able to share confidential medical information (e.g., details related to treatment, symptoms or diagnosis); we can provide functional abilities and limitations for the purposes of facilitating the plan member's return to work or workplace accommodation.

Workplace Solutions for Mental Health

Mental illness is the leading cause of disability claims in Canada and is expected to grow. It cost businesses more than $6 billion in lost productivity due to absenteeism, presenteeism, and turnover in 2011. (Mental Health Commission of Canada: www.mentalhealthcommission.ca) Manulife's Workplace Solutions for Mental Health website was created to provide education and practical workplace tools for both our plan sponsors and plan members who are dealing with mental health issues. You can find the site at www.manulife.ca/mentalhealth.

Long Term Disability (LTD)

About this benefit

What are Long Term Disability benefits?

Part of your group benefits plan, **Long Term Disability (LTD)** insurance provides a plan member with monthly income replacement should an illness or injury occur while they are insured, and cause them to become unable to work for an extended period of time. LTD benefits are payable after a qualifying period has been satisfied, during which time STD benefits, Employment Insurance or salary continuance have been provided. Benefits are normally paid monthly and in arrears.

With LTD benefits, our main focus is working in partnership with you, your front-line managers, supervisors or leaders, and the employee to help your plan member make a safe, timely and effective transition back into the workplace.

LTD benefits are provided according to the terms of your contract.

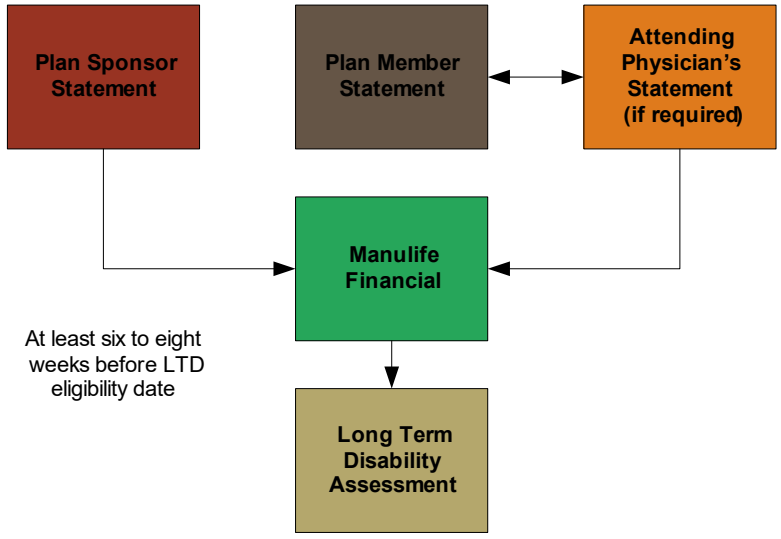
Application

How does the LTD application process work?

The LTD application forms should be submitted to Manulife at least six to eight weeks before the end of the qualifying period in order to allow sufficient lead time to assess the claim. Because Manulife manages your Short Term Disability benefits, the case manager will notify you when the forms should be completed. You will only be asked to complete a condensed **Plan Sponsor Statement**. It is important that all requested LTD claim forms are completed correctly. Missing or incorrect information can result in delays. Please refer to the sample condensed **Plan Sponsor Statement** in the appendix if you need assistance with how to complete the claim form. ***Please note, this process only applies if a claim has NOT transitioned through STDAS.***

Once all required claim forms have been received by Manulife, we can begin assessing the claim.

LONG TERM DISABILITY: APPLICATION



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What's my role?

When it comes to LTD benefits, everyone has a role to play.

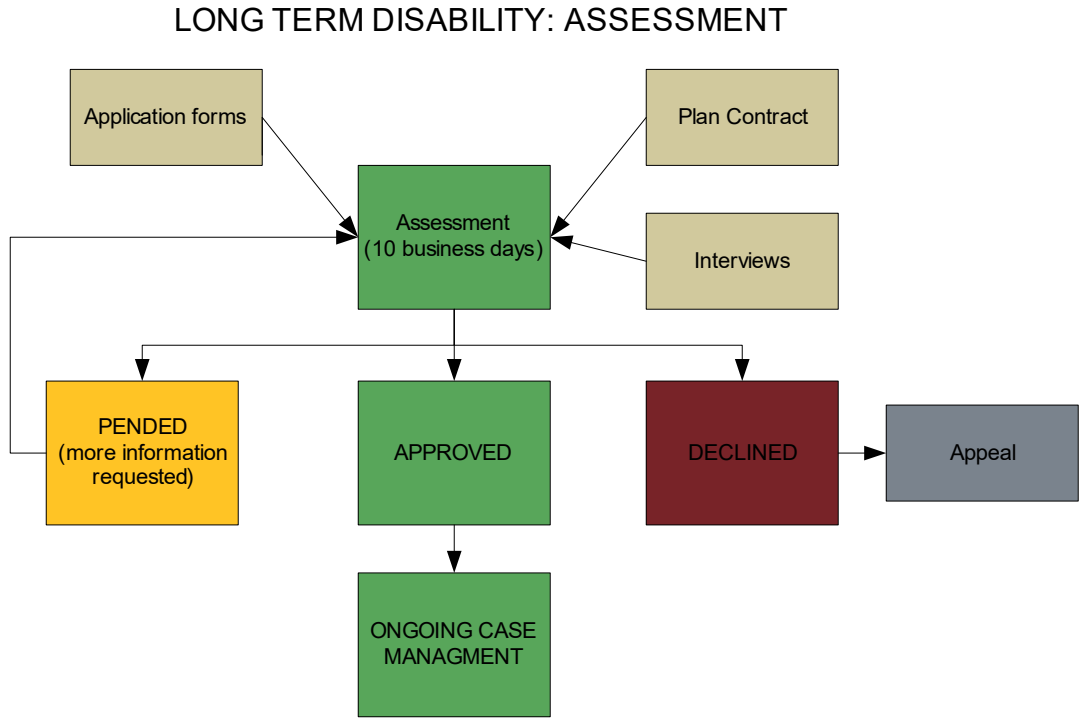
If I'm the:	I need to:
Plan administrator	• Follow up with the plan member and ensure they submit the completed LTD Plan Member statement and any other information requested by the case manager, to Manulife at least six to eight weeks before the end of the LTD qualifying period. • Complete and submit the condensed LTD **Plan Sponsor Statement** to Manulife. Please ensure you complete all fields. • Continue to stay in contact with the plan member to provide support and preserve their connection with the workplace. • Follow up periodically to ensure that any outstanding forms or information has been submitted to Manulife.
Plan member	• Complete and submit the LTD **Plan Member Statement** to Manulife by fax or mail. • Pay any fees required by the doctor for getting the necessary medical information or forms completed. • Follow the instructions provided for the appropriate care and treatment of their condition. • Let the plan administrator know when they are capable of returning to work with full or modified duties. • Report any work activity and/or income (other than salary continuance or STD benefits) received during the LTD qualifying or LTD benefits period to the case manager. • Stay in contact with their direct supervisor, manager or plan administrator.
Attending physician	• If required, complete the Initial **Attending Physician's Statement (IAPS)** or Update and provide any relevant documentation, clinical findings, restrictions and limitations, consultation reports, test results and chart notes or respond to any requests for information that may be needed by the case manager to complete the assessment. • Return any required forms or documents to the plan member or submit the information directly to Manulife by fax or mail.
LTD case manager	• Work with the STD/AMS case manager to ensure a smooth transition of the claim. • Follow up with the plan administrator for any outstanding forms after 10 business days. • Assess the LTD claim once all required forms have been received by Manulife.

Assessment

How does assessment of a LTD claim work?

Once all required claim forms have been received by Manulife, the LTD case manager can begin to review the claim and your contract. They may also conduct telephone interviews with the plan member and plan administrator or supervisor. The assessment should be completed within 10 business days of receiving all required forms.

Both you and the plan member will be notified when the claim has been approved, declined or pended (until additional information can be provided).



What's my role?

When it comes to LTD benefits, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Provide details about the plan member's essential duties, work environment and any relevant work-related issues to the case manager. • Participate in telephone interviews with the case manager. • Advise the case manager and plan member if modified work duties or accommodations may be available and ensure they are implemented safely.
Plan member	• Participate in telephone interviews with the case manager. • Provide any additional information or documentation that may be required by the case manager to complete the assessment of the claim.

Attending physician	• Continue to provide medical support to promote an active recovery. • Provide any additional medical information requested by the case manager. • Charge reasonable and customary fees for providing the requested information.

If I'm the:	I need to:
LTD case manager	• Work with the STD/AMS case manager to ensure a smooth transition to LTD. • Review the relevant terms of the contract, claim forms, medical information and other documents submitted as part of the LTD claim application. • Determine if additional information or documentation may be required to complete the assessment of the claim. • Work with the plan member, plan administrator and attending physician to identify opportunities or modifications to support a safe and timely return to work. • Conduct telephone interviews with the plan member and plan administrator or direct supervisor to clarify claims details, work duties, salary information and any return to work barriers. • Provide a decision on the LTD claims application within 10 business days of receiving all required LTD forms. • Ensure the benefit is paid promptly, as outlined in the contract.

How will I find out about a claims decision?

Once all required forms have been received by Manulife, you can expect to receive a decision on an LTD claim within 10 business days.

If I'm the:	I will receive:
Plan administrator	• Notification (phone, email or letter) from the case manager advising if the claim has been approved, denied or pended (awaiting further information to complete the assessment). • For all denials - you will be notified by the case manager of the decision prior to our communication with the plan member. This provides your team with the opportunity to advise us of any new developments you are aware of, address any concerns you may have, and to initiate any actions required to assist the plan member in returning to the work place or in supporting your plan member should they decide to appeal.
Plan member	• A phone call by the case manager confirming our decision, rationale and next steps. This will be followed up with a detailed letter. If the claim is: ○ **Approved** - The case manager provides a decision letter summarizing the conditions leading to their decision, a calculation of the benefits amount, expected duration, case management action plan and next steps. LTD benefits are issued monthly, on the last day of the month, and cover the previous month. ○ **Denied** - The case manager's decision letter provides a clear and complete explanation of the rationale for the outcome. It also provides instructions for making an appeal. ○ **Pended** - The case manager's letter outlines any additional information that may be required to complete the assessment of the LTD claim.

Manulife

Case Management

How does the case management process work?

All newly approved LTD cases are considered for Rehabilitation Services to determine if there is any immediate rehabilitation potential. In addition, the claim is reviewed with the plan member's supervisor/manager to determine if there is an immediate opportunity to accommodate the plan member given his or her present capabilities.

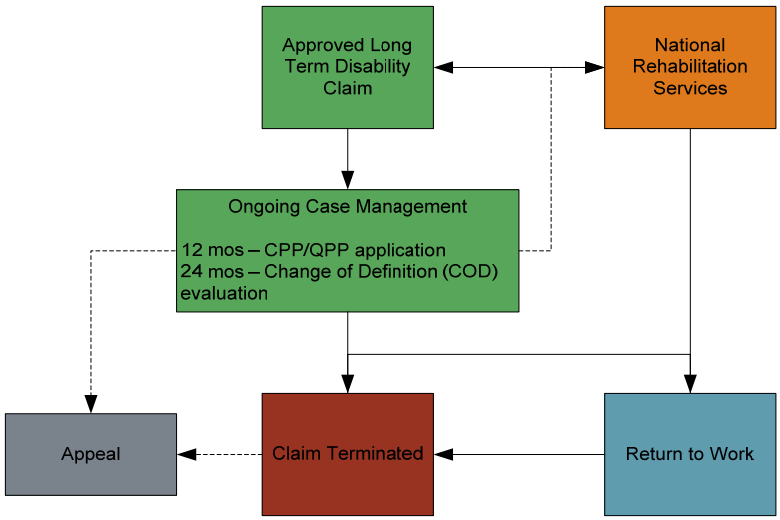
The case manager manages the file in accordance with an outcome focused Case Management Action Plan. The Case Management Action Plan is created during our initial assessment and decision process. It details the case manager's analysis, expected outcomes, and next steps for ongoing case management. Throughout the claim, the action plan is updated and adjusted in accordance with new findings or developments.

When there are adjustments to the action plan, the plan member and plan administrator are advised of the revised goals, actions and/or requirements, and time-frames.

At each review, consideration is given to rehabilitation potential and timing, as well as to the use of specific case management tools and resources to assist the employee with functional improvement and work readiness.

Ongoing communications and case management support are provided until the plan member makes a timely, safe and sustainable return to work, the maximum benefit has been reached, or the claim is terminated.

LONG TERM DISABILITY: ONGOING CASE MANAGEMENT



When would a case be referred for rehabilitation services?

All newly approved LTD cases are pre-screened by our National Rehabilitation Services intake team to identify any immediate rehabilitation potential. Cases may also be referred for rehabilitation review at any point during the ongoing case management process if the case manager determines that rehabilitation support may be of benefit.

Services provided by this team include:

- **Functional rehabilitation** - helping plan members return to their own occupation;
- **Vocational rehabilitation** - helping plan members prepare for alternative employment opportunities; and
- **Work facilitation** - helping plan members overcome non-medical barriers that could inhibit their successful return to work

In some situations, rehabilitation intervention may not be appropriate, such as when:

- a medical condition is unstable,
- rehab intervention will not improve the member's chances of resuming gainful employment,
- there is a medical release to return to work in one month or less (unless the employer or plan member indicate that assistance is needed).

What's my role?

When it comes to LTD benefits, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Maintain contact with the plan member to provide support and preserve their connection with the workplace. • Work with the case manager to identify opportunities for modified duties or accommodations that would support a safe, timely and effective return to work. • Share information with our case managers and rehabilitation specialists regarding your employee's ability to perform the work prior to the absence/disability, the anticipated barriers (if any) on return, and any other information such as non-medical work related barriers.
Plan member	• Stay in touch with the case manager, as requested, and provide updates should their medical status change. • Actively participate in the treatment recommendations as outlined by their health care providers. • Work with the case manager and plan administrator to identify opportunities for modified duties or accommodations that would support a safe, timely and sustainable return to work. • Apply for Canada Pension Plan (CPP)/Quebec Pension Plan (QPP) benefits or other sources of income such as workers compensation when requested by their case manager. • Inform the case manager about the status of their CPP/QPP application once notification has been received. • Report any work activity and/or income received other than LTD benefits to the case manager. • Keep in touch with their employer and inform them of their progress and readiness for return to work.
Attending physician	• Provide medical support and recommendations to promote an active recovery. • Provide any additional medical information to Manulife or the plan member when requested by the case manager. This may include completing the Attending Physician's Update and CPP/QPP benefits forms. • Work with the case manager, plan administrator and plan member to identify opportunities for modified duties or accommodations that would support a safe, timely and sustainable return to work. • Provide the case manager with the plan member's functional abilities to assist with identifying return to work opportunities.

If I'm the:	I need to:
LTD case manager	• Request any additional information that may be required based on their assessment of the claim. • Conduct regular phone updates with the plan member to assess their progress, functional abilities, ongoing treatment plans, and readiness for return to work. • Conduct phone updates with the plan sponsor to advise of expected claim durations, functional abilities, case management next steps and return to work options. • Follow-up with treatment providers for any information still outstanding and provide notification to the member if benefits may be suspended. • Review any new medical information within 10 business days of receipt. • Work with attending physician, plan administrator and plan member to identify opportunities for modified duties or accommodations that would support a safe, timely and sustainable return to work. • Access the support and resources needed to actively manage the claim in a timely manner (e.g., Manulife's medical consultants, mental health specialists, rehabilitation services, Independent Medical Evaluations). • Ensure the benefit is paid as outlined in the plan contract. • Ensure the plan member has applied for CPP/QPP benefits and any other income sources, as appropriate, and that they are aware of the outcome of the application (e.g., benefits reduced).

National rehabilitation services	• Work with case managers to determine appropriate rehabilitation actions and timing:
	  ○ **Functional rehabilitation** - helping plan members return to their own occupation;
	  ○ **Vocational rehabilitation** - helping plan members prepare for alternative employment opportunities;
	  ○ **Work facilitation** - helping plan members overcome barriers that could inhibit their successful return to work.

Manulife

Return to Work / Rehabilitation

Why should I offer a return to work program?

After a prolonged absence, a plan member may benefit from a gradual return to work program. Many injured or ill employees can safely perform productive work as they continue to recover from their disability. A modified return to work program not only helps employees to know they are valued but it can decrease claim durations and the risk of relapse. Your Manulife case manager or rehabilitation consultant will contact you when the plan member is ready to begin a return to work. You will be given sufficient lead time to prepare for their re-entry.

What's my role?

When it comes to LTD benefits, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Review the Return to Work Guide for Managers for information to help support your employee's return to the workplace. • Work with the case manager or rehabilitation consultant to design a return to work plan that is suitable to the employee and the work environment. • Review the return to work plan with the plan member. • Prepare for the plan member's return to work by ensuring workstation, access, and computers are available. • Notify co-workers of the plan member's return to work and any details with respect to the plan that may affect them. Ensure they are prepared to be supportive. • Provide confirmation of part-time (rehab) earnings to the case manager at the end of each month during the return to work period. Include the number of hours worked, as well as gross and net earnings. • Request additional support from the case manager or rehabilitation specialist when required. • Contact Manulife if it is evident the employee is experiencing difficulties during the return to work. • Contact Manulife if the employee is absent on any scheduled days during the return to work program.
Plan member	• Review the Return to Work Guide for Employees to help prepare for their return to the workplace. • Participate in developing the return to work plan with the plan administrator, direct manager or supervisor before returning to the workplace. • Establish regular meetings with the direct supervisor or manager, as required, to review return to work progress and resumption of essential duties. • Actively participate in any medical treatment or rehabilitation program required to support the return to work plan. • Contact the case manager or rehabilitation specialist with any questions or concerns throughout the return to work process. • Notify the supervisor or manager, and Manulife case manager or rehab consultant if they are struggling with aspects of the return to work plan. Work with them to make necessary adjustments, if required.

If I'm the:	I need to:
LTD case manager	• Work with the plan administrator, plan member, attending physician and our rehabilitation specialists to find the best solutions for the return to work plan. • Address any questions or concerns throughout the return to work process. • Ensure the plan administrator has provided confirmation of the plan member's part-time (rehab) earnings at the end of each month. • Factor any part time earnings into the monthly LTD benefit amount.
Functional rehabilitation specialist	• Work with plan administrator, plan member, case manager and other Manulife specialists, as required, to find ways to resolve functional impairments and enable the plan member to return to work in their own occupation. This may include: ○ assessing medical information, ○ identifying barriers; and ○ evaluating worksite ergonomics. • Address any questions or concerns throughout the return to work process. • Manage and coordinate return to work activities.
Work facilitation specialist	• When requested, facilitate a meeting to address any non-medical barriers in the workplace. • When requested, conduct worksite or ergonomic assessments to address functional barriers affecting the return to work. • Ensure the plan administrator, plan member and physician are aware of and support the goals and timelines outlined in the return to work plan.
Vocational rehabilitation specialist	• Work with the plan member to identify alternative employment opportunities that align with their functional capabilities, education, training and experience. • Access Manulife's network of specialized vocational evaluation resources, such as: ○ aptitude and personality testing; ○ resume preparation and job search training; as well as ○ other services to help prepare plan members for re-entry to the labour market.
Attending physician	• Provide medical support and recommendations to promote an active recovery. • Provide any additional medical information to Manulife or the plan member when requested by the case manager. • When requested, review and provide comments on any return to work proposals.

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Change of Definition (COD)

What is Change of Definition (COD)?

Change of Definition (COD) is a point in the claim (usually 24 months after the end of the LTD qualifying period) when the definition of disability changes from "own occupation" to "any occupation".

In assessing an "own occupation" definition of disability we compare the plan member's medically supported functional abilities and limitations with the essential duties of their own occupation. Own occupation refers to the classification of the essential duties, demands, skills and requirements of the type of work performed by the member prior to their disability.

The essential duties of the occupation may include:

- those required to perform the occupation;
- those that cannot be reasonably omitted or modified;
- those that are fundamental to the occupation;
- those done at a frequency and/or duration that cannot be omitted.

How does the COD process work?

In assessing eligibility under an "any occupation" definition of disability, we determine whether the plan member is totally disabled from performing the essential duties of ***any occupation*** for which they are qualified by training, education and experience. Our assessment includes a review of:

- the nature and extent of the plan member's functional impairment;
- the plan member's functional abilities;
- the plan member's transferable skills;
- the demands of alternate occupations;
- the means test (level of earnings that must be met) outlined in the contract.

If the contract does not contain a "means test", a guideline of 65% of gross pre-disability income is used as a measure of "reasonable" earnings ability.

The availability of jobs or work is not a consideration in assessing disability.

If we know from the onset of a claim that a plan member will not be able to return to the demands of his/her own occupation, our case manager will immediately explore the availability of early accommodation opportunities and/or alternate occupations within your organization.

If suitable alternate work within your organization is not readily identifiable, and we are unable to identify suitable work elsewhere, our case managers conduct a Transferable Skills Analysis using a specialized software program and other resources (e.g., government web sites) to determine if there are suitable alternate occupations which the plan member is capable of performing.

If required, we will arrange a referral to vocational or functional rehabilitation services to assist the plan member with their re-entry into the workforce. We look to initiate these services well within the own occupation period so that the plan member can re-join the work force in a suitable role or is work ready by the time the change of definition is reached. We communicate regularly with the plan member and plan administrator to ensure there are no surprises at the Change of Definition.

Manulife

What's my role?

When it comes to LTD benefits, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Identify any opportunities for modified duties or accommodations that would support a safe, timely and sustainable return to work, or transition to an alternate occupation within the organization if required.
Plan member	• Provide any additional information that may be requested by the case manager to complete the COD evaluation. • Participate in any vocational rehabilitation that may be requested by the case manager. • Work with the case manager/rehabilitation specialist to identify opportunities for alternate employment based on their skill set and functional abilities. • Continue to work with and follow the treatment plan recommended by healthcare providers.
Attending physician	• Provide any medical information that may be requested by the case manager.
LTD case manager	• From receipt of the LTD claim, assess the claim based on both the own occupation definition of total disability and the any occupation definition. • Educate the plan member and plan administrator about the COD evaluation upon claim approval and throughout the claim process. • Conduct ongoing evaluations and ensure information is requested in a timely manner to support the COD process at least six months prior to COD date. • Assess the plan member's functional capacity to perform the essential duties of their own occupation or other employment alternatives and determine if they continue to meet the definition of total disability as outlined in your contract. • Assess the plan member's education, training and skills that would be transferrable to an alternative occupation. • Refer the case for review and involvement by functional or vocational rehabilitation services, if appropriate.

How will I learn the outcome of the COD evaluation?

The case manager will provide written notification about COD evaluation as soon as a determination has been reached.

If I'm the:	I will receive:
Plan administrator	• Notification (by phone call, email or letter) from the case manager if the claim has been approved (benefits continued) or terminated.
Plan member	• A letter outlining the details and rationale used in making our decision. If the claim is: ○ **Approved** - The case manager provides a decision letter advising that continuation of claim and monthly LTD benefits has been approved. This letter also details rehabilitation involvement that may be required following the COD evaluation. ○ **Terminated** - The case manager provides a clear and complete overview of the COD evaluation, along with the rationale leading to the COD decision and the date that payment of LTD benefits will end. The letter also provides instructions for making an appeal.

Appeals

How does the appeals process work?

At Manulife, we believe employees should be offered the option to appeal when their case is not supported for medical reasons. An appeal is a written request from the employee that asks Manulife to revisit the decision on their medically declined file.

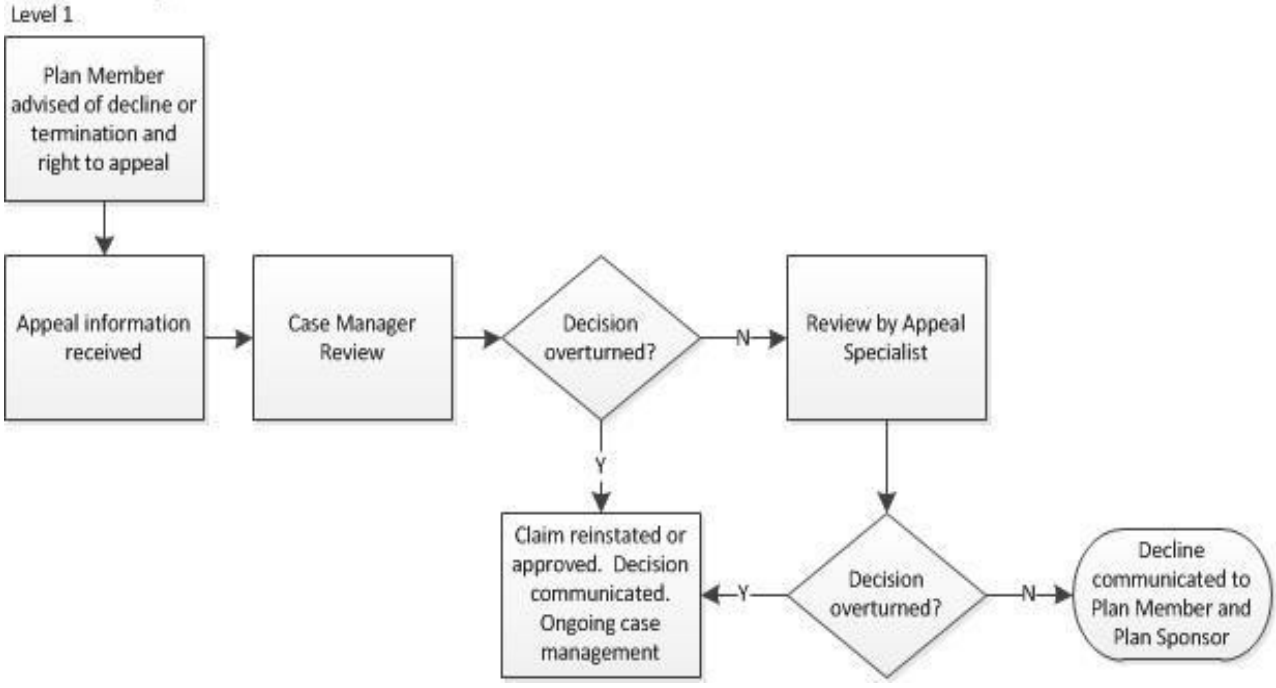
When a plan member appeals a LTD claims decision, a different case manager or appeals specialist will manage the file. There are three levels of appeals, each requiring that new unreviewed medical evidence is provided. We seek to reach decisions or provide updates on appeals within 30 calendar days.

Employees are encouraged to file their appeal in writing within 60 days of receiving the decision letter. Employees are advised that Manulife will not consider or review any appeals which are submitted after a set date. The date is the later of 12 months from the date benefits cease or 12 months from the date of the decline or termination letter. This date does not change during the course of the appeal process.

The appeal process is exhausted on the earlier of the completion of the third level of appeal or the 12 months period from the date of declination or termination.

LTD Appeal Process

Appeal information must be submitted within 60 days of the date of the decline/termination letter. Manulife Financial will not consider/review any appeals which are submitted greater than 12 months from the date benefits ceased or the date of the decline/termination letter – whichever is greater.



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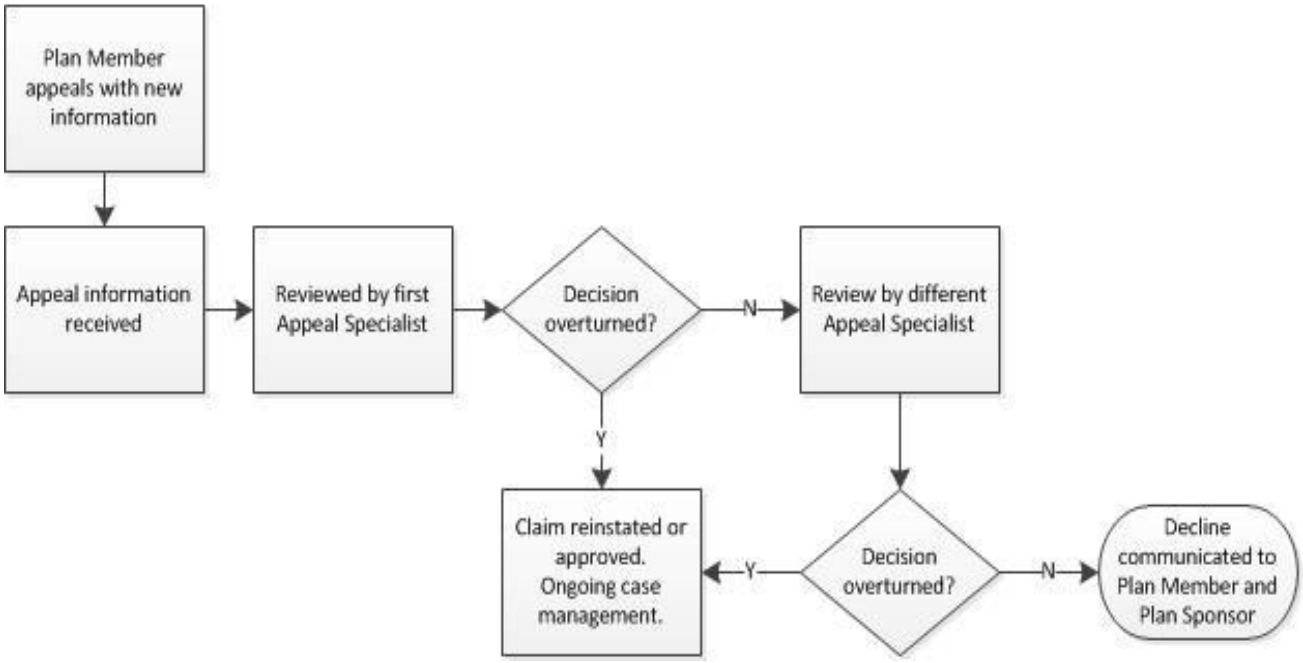
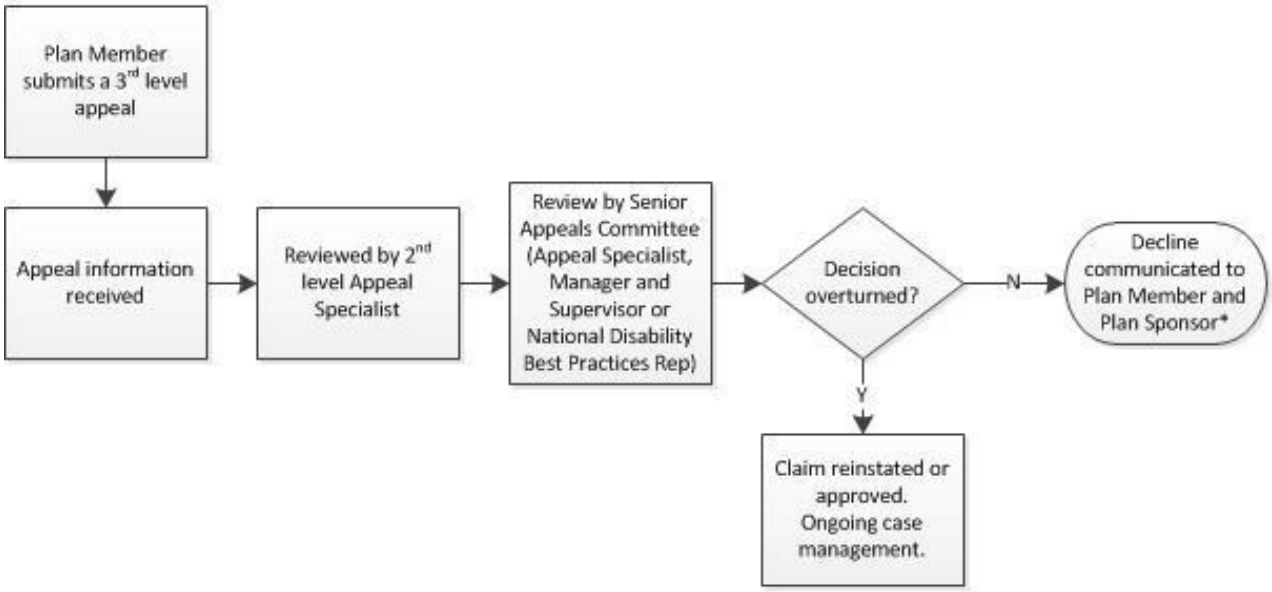
Level 2



Level 3



* If Plan Member disagrees with 3rd Level Appeal decision and the plan is insured, they are directed to the OmbudService for Life & Health Insurance.

What's my role?

When it comes to LTD benefits, everyone has a role to play.

If I'm the:	I need to:
Plan administrator	• Direct any questions about the appeals process to the case manager.
Plan member	• Notify Manulife in writing, within 60 days from the date of the decision letter, if they wish to appeal. • Notification should include the reason(s) why they disagree with the decision, as well as any additional medical information or evidence they have to support their position. The plan member should review the decision letter with their attending physician to determine the type of information that will be needed to support their appeal. • Complete the **Plan Member Authorization to Share Information** form, if requested by the case manager.
Attending physician	• Provide any additional information required in relation to the appeal.
LTD case manager	• Review appeal information. If decline decision is maintained, refer claim to appeal specialist. If claim is reinstated or approved, communicate decision to plan member and plan sponsor.
Appeals specialist	• Acknowledge receipt of an appeal within 10 business days. • Conduct an initial review to determine if further information or investigation will be required to complete the appeals process. • Gather the required information or conduct any further investigation (e.g., medical, vocational, etc.) needed to complete the appeal. • Engage additional resources and support as required (e.g., Manulife Claims Director, Manulife consulting physicians and affiliated Manulife Disability Best Practices Specialists). • Provide a decision or status update on the appeal within 30 calendar days from the date the appeal was received.

How will I find out about an appeals decision?

You can expect to receive confirmation of a plan member's intent to appeal an LTD claims decision within 10 business days of its receipt in writing by the case manager. The case manager or appeals specialist will provide written notification of the appeals decision within 30 business days.

If I'm the:	I will receive:
Plan administrator	• Acknowledgement of the plan member's intent to appeal - within 10 business days of receipt. • Notification of the decision from the case manager or appeals specialist, within 30 calendar days if the case has been **reinstated** or **maintained**.
Plan member	• **Acknowledgement letter** sent by the case manager confirming receipt of the plan member's intent to appeal - within 10 business days of receipt. • Letter of decision notification, sent by the case manager or appeals specialist within 30 business days. **If the decision on the claim has been...** ○ **Reversed** - The case manager or appeals specialist sends a **decision letter** advising the claim has been reinstated and will return to ongoing case management. ○ **Maintained** - The case manager or appeals specialist issues a **decision letter** providing detailed information about the assessment of the appeal and the rationale for the decision.

Forms

Where can I find LTD claim forms?

When Manulife manages the short term disability benefit period, we will advise of and send the LTD forms required for application. In the event that you wish to access the forms, they can be found in the forms section of the Plan Administrator Secure Site:

- Plan Sponsor statement (condensed version GL 3237);
- Member statement;
- Attending Physician's statement; and the
- LTD Benefits Guide.

Guide to completing LTD claim forms

When it comes to LTD benefits, we need to gather information from you, the plan member, and (in some cases) the plan member's physician(s) in order to assess the claim. We're unable to begin reviewing a claim until each of the forms have been completed and submitted to Manulife.

Be sure to include the plan member's earnings and complete all applicable fields. An incomplete form may result in delays in the adjudication of the plan member's disability claim, so please take a moment to ensure that nothing has been overlooked and follow-up to ensure that all forms have been submitted.

Please refer to the sample claims guide for assistance with completing some sections of the condensed Plan Sponsor statement.

Frequently Asked Questions

How do you determine the essential duties of a plan member's occupation?

Essential duties are usually:

- those required to perform the occupation
- those that cannot be reasonably omitted or modified
- those that are fundamental to the occupation
- those done at a frequency and/or duration that cannot be omitted

In determining the essential duties of the occupation, the case manager will review the job description and duties outlined on the plan sponsor and plan member forms. The case manager may also contact the plan member and/or plan sponsor to review the job description and clarify essential duties.

Do I need to submit a disability claim if the plan member is working modified duties?

A request for modified work must be medically supported. In most cases, accommodations should be temporary with a progression towards full time hours and duties. If the plan member's earnings are not impacted and the modification is for a short duration, you may not need to submit a claim. However, if the modified work program or rehabilitation program is expected to extend beyond the midpoint of the STD benefit period, or within eight weeks of the end of the LTD qualifying period, you will need to submit the STD claim. If you are in doubt or have questions about a specific case, please contact your STD case manager to discuss.

If a plan member is on a WSIB/WCB claim, do I need to notify Manulife?

For STD, LTD and Life Waiver of premium (LW), the assessment of disability starts on the date the plan member became disabled due to a work-related illness or injury. For those plan members with STD, LTD and/or LW, we recommend initiation of the claim application process within eight weeks of the end of the LTD/LW Qualifying Period.

In the event the WSIB/WCB claim closes for reasons not related to recovery and return to work own occupation (e.g., due to the onset of another condition for which WSIB/WCB is not payable) the LTD claim is already established and Manulife can proceed with assessment of eligibility. This eliminates the potential for delays associated with late notification and/or filing of proof of claim. Please note, the assessment of disability starts on the date the plan member was injured or absent from work due to a work related incident.

What happens if a plan member becomes disabled while on strike or an indefinite layoff?

Disability coverage ceases as of the last day Actively at Work. If a plan member becomes disabled during the strike or indefinite layoff, the plan member is ineligible to claim for disability benefits.

What happens if a plan member becomes disabled while on maternity or parental leave, or while on a temporary layoff or leave of absence?

The handling is dependent upon whether disability coverage is available and is continued during the specific form of leave of absence or temporary layoff.

Under our standard contract wording,

- For maternity and parental leaves, disability coverage can be continued during the period of leave to which the plan member is entitled by legislation governing the plan sponsor.

- For temporary layoff and other leaves of absence, disability coverage can be continued at the plan sponsor's election to a maximum period of 120 days from the date the plan member was last actively at work.

Coverage continuations for other durations may be considered by Manulife on a case by case basis. Manulife must be advised and approve of any exceptions in advance.

If disability coverage is continued and a plan member becomes disabled during the leave of absence or temporary layoff, the qualifying period starts as of the date of disability and benefits become payable on the later of the date the qualifying period is satisfied, or the date the plan member is scheduled to return to work.

What do I need to do if a member's claim is declined or terminated?

Please refer to the plan administrator responsibilities sections of this guide for the various claim termination/decline situations. In general, if a claim has been declined or terminated, you should be contacting your plan member to discuss whether they will be appealing Manulife's decision to decline or terminate their claim. If the plan member is not appealing our decision, you should discuss return to work options with them as per your internal policies and procedures.

Why does the plan member have to apply for CPP/QPP and how does the process work?

Canada/Quebec Pension Plan (C/QPP) disability benefits are available to eligible employees with a severe and prolonged disability. There is a contractual requirement for plan members to apply for these benefits, if eligible. C/QPP disability benefits are an offset under the standard LTD policy and therefore the LTD benefit will be reduced by the monthly benefit awarded by C/QPP. Manulife offsets the initial disability award. We do not usually increase the offset by any future cost of living increases that may be awarded by C/QPP, unless the Plan specifically provides for this.

In general, we ask the plan members to apply for C/QPP disability benefits no later than 12 months following the date of disability unless there is a strong likelihood of a return to work. If it is clear that the plan member will most likely meet the C/QPP eligibility requirements immediately, they may be asked to apply for C/QPP as soon as the claim is approved. The case manager will contact the plan member by phone to discuss the application process and outline the requirements. They will follow up with a letter directing the plan member to the C/QPP application forms (we direct them to the C/QPP website or we include an application kit). The following forms are often included in the letter sent to the plan member:

Form	Details
Irrevocable Consent to Deduct and Pay an Insurer	Human Resources and Skills Development Canada (HRSDC) form - Assigns retroactive primary disability benefits payable by Canada Pension Plan to Manulife.
Reimbursement Agreement	Agreement that you or your estate is liable for reimbursing any overpayment that is not recovered under the above assignment.
Consent for Service Canada and Insurer to Communicate Disability Benefit Information	HRSDC form permits release of information to Manulife regarding the status of application for disability benefits.
Authorization to Disclose Information/Consent for Medical Evaluation	HRSDC form - Consent to release medical and vocational information that we have on file to CPP in order to assist in your application for CPP disability benefits.

The approval process for C/QPP disability benefits and the approval process for LTD benefits are separate and unrelated. Approval of one benefit does not determine or influence the approval of the other benefit.

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If an employee is off on disability, when should they stop paying STD and LTD premiums?

Premiums should only be discontinued when Manulife approves the waiver of premiums on LTD and/or Life claims.

For waiver of premiums on Life and LTD benefit coverage, the Waiver begins on the next premium due date coincident with or following the approval date of the LTD or Life waiver claim.

If your account/policy is administered through Head Office, the premium adjustments will flow through upon acceptance of the claim. If your account/policy is self-administered, reconciliation can occur once you receive confirmation of claim approval.

Important Information

Protecting plan member privacy

Protecting the privacy of our plan members is at the forefront of everything we do. We can only communicate confidential claims information if we have a signed authorization from the plan member. See our privacy policy for details about the information.

What information can we provide to you?

We are able to share administrative and payment information with you, including claim status, the amount of benefit payment, amounts paid by any employer or other source that may be offset from the benefit payment (e.g., CPP disability payments). While we are not able to share confidential medical information (e.g., details related to treatment, symptoms or diagnosis); we can provide functional abilities and limitations for the purposes of facilitating the plan member's return to work or workplace accommodation.

Workplace Solutions for Mental Health

Mental illness is the leading cause of disability claims in Canada and is expected to grow. It cost businesses more than $6 billion in lost productivity due to absenteeism, presenteeism, and turnover in 2011. (Mental Health Commission of Canada: www.mentalhealthcommission.ca) Manulife's Workplace Solutions for Mental Health website was created to provide education and practical workplace tools for both our plan sponsors and plan members who are dealing with mental health issues. You can find the site at www.manulife.ca/mentalhealth.