Manulife

This is further to your recent request for Job Loss benefits on the above referenced insurance. In order for us to assess your claim, please complete the relevant sections of the attached claim form. See "Instructions for completing this form" on the first page of the claim form.

Employee:

- Section 1 is to be completed by you.
- Section 2 is to be completed by your employer.
- Enclose a copy of your Record of Employment and all Employment Insurance (EI) stubs, if available.

Self-employed:

- Sections 1 and 2 are to be completed by you.
- Enclose a copy of the applicable business forms and statements, such as:
  - Copy of proof of business registration;
  - T1 & T2125
  - Notice of Assessment for the previous year prior to your job loss.

Please refer to the Job Loss insurance section of your Policy for details regarding this coverage. Incomplete claim forms will result in delays in assessing your claim.

Please submit all required documentation to us within 90 days of the date of your job loss. If you cannot meet this deadline, send your claim in as soon as you possibly can. Manulife will not accept any claims after one year has passed from the date of your job loss.

Your claim will be assessed based on the information provided, or we will let you know if additional information is required, and keep you advised as to the status of your claim.

In the interim, we ask that you continue to pay premiums as billed until a decision has been made. Upon receipt of the above, prompt attention will be given to your claim. Should you require further assistance, please feel free to contact our office at the number shown below.

Sincerely,

Creditor Claims
Affinity Markets

Manulife

Affinity Markets Initial Claim

• Waiver of Premium for Job Loss Insurance

The Manufacturers Life Insurance Company is hereinafter referred to as Manulife.

Instructions for completing this form

The hope is that the information provided on the claim forms will allow us to make a decision on your claim. If it does not, we will be in touch with you promptly to keep you advised of the progress of the adjudication of your claim.

• **Section 1** - Claimant's Statement. Please complete all pertinent sections in full. Read and sign the "Certification, assignment and authorization" section.

Job Loss/Employee:
• **Section 2** - Job Loss Employer Statement to be fully completed by your employer. Enclose a copy of the Record of Employment and all Employment Insurance (E.I.) stubs.

Job Loss/Self-employed:
• **Section 3** - Job Loss Self-employed Statement to be completed by insured member.

Please send the completed forms and other documentation to us at:

Manulife
Affinity Markets
Claims Administration
PO Box 11023
Stn Centre-Ville
Montreal QC H3C 4V7

Toll free: 1-800-387-0048

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Claimant's Statement

This portion is to be completed by the insured member.

- Only the insured member may claim for Job Loss benefit.

It is certified that to the best of the knowledge and belief of the undersigned the statements are complete and true and it is agreed that issuance of this form is not considered an admission of liability on the part of the insurer.

Section 1

1 Personal information

Name (last, first, initial)			Policy number
Address (number, street and apt. number)			
City	Province	Postal code	Date of birth (dd/mmm/yyyy)
Residence phone number ( )	Business phone number ( )	Fax number ( )	◯ Male ◯ Female

2 Employment information

Employee

Occupation	
◯ Full-time HRS/WK _____ HRS/MTH _____	◯ Part-time HRS/WK _____ HRS/MTH _____
Name of employer	Employer's telephone number ( )
Address of employer	Postal code

Self-employed

Are you self-employed? ◯ Yes ◯ No	If *yes*, please provide the information below.		
Name of your company or business			
Address	City	Province	Postal code
Is your business still operating? ◯ Yes ◯ No			

3 Certification, assignment and authorization

I certify that the information in this claim form is complete, current and accurate to the best of my knowledge and belief. I am aware that the issuance of this claim form is not to be construed as an admission of liability on the part of Manulife or its agents.

I agree to refund any monies, which may be due to Manulife as a result of over-payment of benefits in accordance with the provisions of the particular benefit plan with Manulife.

I understand that Manulife, its reinsurer(s), agents, third party administrators, or its legal counsel will require information for the purpose of establishing or reviewing the validity of the claim or for the purpose of determining whether benefits are payable and the entitlement and amounts of benefits.

I authorize any employer, insurance company, corporation, organization, institution, association, or person that has any information, record or knowledge regarding my claim to release and exchange any and all employment information or any information or records that may be requested to Manulife, its reinsurer(s), agents, third party administrators, or its legal representatives.

I authorize any other insurance carrier, corporation, organization or person who has knowledge of this or any other claim relating to me to release and exchange with Manulife or it agents any employment information, benefit payment information, or claim information that may be requested in order to allow the validity of this claim to be reviewed or for the claim to be investigated.

I understand why I have been asked to disclose this information, including my individually identifying information, and am aware of the risks and benefits of consenting or refusing to consent to the disclosure of the information listed above.

I understand that I may revoke this consent at any time.

I also understand that if I revoke my consent, the recipient of this information will be unable to fulfil the purpose(s) stated above.

I agree that a photocopy or facsimile of this authorization shall be as valid as the original. This consent is effective on the date stated below, and is valid for five (5) years or the continuation of the claim whichever is longer.

continued...

3 Certification, assignment and authorization *(continued)*

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Fraud Notice: Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties. In addition the insurer may deny insurance benefits if false information materially related to a claim or an application for insurance was provided by the applicant.

Print name of insured member	Certificate number(s)
Please sign here ▶ Insured member signature ✘	Date signed (dd/mmm/yyyy)

4 Confidentiality

The specific and detailed information requested on this claim form is required to process and adjudicate your claim. To protect your confidentiality of this information, Manulife will establish a "Claim File" from which this information will be used to administer and process your claim. Access to this file will be restricted to those Manulife employees, mandataries, third party administrators, legal representatives or agents who are responsible for the investigation of claims, and to any other person you authorize or who are authorized by law.

Your file is secured in our office or the offices of our third party administrators.

You may request to review the personal information in this file and make any correction in writing. To initiate the review, send a request in writing, to Privacy Officer The Manufacturers Life Insurance Company Affinity Markets.

PRIVACY OFFICER
MANULIFE
PO BOX 1602
DEL STN 500-4-A
WATERLOO ON N2J 4C6

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Job Loss
Employer Statement

To be completed by employer.

Section 2

Name of employee (first, middle initial, last)			
Title/position			
Company name			
Address (number, street and suite)	City	Province	Postal code
Business phone number ( )	Fax number ( )		

Type of employment (please check one)
◯ Full-time ◯ Part-time ◯ Seasonal ◯ Temporary/contract

Number of hours worked per week	First date worked (dd/mmm/yyyy)	Last date worked (dd/mmm/yyyy)

Reason for employment status ◯ Dismissed* ◯ Lay off** ◯ Closure of business ◯ Retirement ◯ Other (please specify) _____	Expected return date (dd/mmm/yyyy)

When was the employee first notified of job termination?

*If termination is due to dismissal, indicate the reason for the dismissal.

**If lay off is temporary, when is the anticipated return to work date?

Was this employment a normal seasonal employment? ◯ Yes ◯ No

Termination of employment was ◯ Voluntary ◯ Involuntary

Name of person who completed this statement (first, middle initial, last)

Title/position

Please sign here ▶

Signature ✘	Date (dd/mmm/yyyy)

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Job Loss
Self-employment Statement

To be completed by the self-employed insured member.

Section 3

Name of insured member (first, middle initial, last)	Date of birth (dd/mmm/yyyy)
Business name	
Location	
◯ Sole proprietorship (Provide T1 & T2125 and Notice of Assessment.) ◯ Owner Partnership: Holds ( )% of business in partnership, major decision maker and holds control of business ◯ Corporation (Provide Financial Statements & T2 and Schedules 1, 9, & 50.) ◯ Attach copy of proof of business registration	
Please briefly explain your business and what it does	
Date of start of your business (dd/mmm/yyyy)	Date of closure of your business (dd/mmm/yyyy)
Reason for the closure of your business	
How many hours did you work per week?	
Is this job loss: ◯ Temporary ◯ Permanent	If temporary when do you anticipate to return to work? (dd/mmm/yyyy)
Was this a continuous period of employment? ◯ Yes ◯ No	
If *no*, how long was the period of employment immediately prior to the termination date?	
Are you currently working? ◯ Yes ◯ No	If *yes*, provide the date you returned to work (dd/mmm/yyyy)
Did your job loss result from: ◯ Closure of business due to wilful misconduct or criminal misconduct ◯ Retirement ◯ The regular end of a seasonal employment ◯ Voluntary forfeiture of salary, wages or income ◯ Temporary/contract employment	
Name of person who completed this statement (first, middle initial, last)	
Signature ✘	Date (dd/mmm/yyyy)

Please sign here ▶