Long Term Disability Claim

An incomplete form may result in delays in the adjudication of your disability claim.

Once completed, please send the claim form to:

Executive Director
Pension Office Corporation
625 Church Street, Suite 401
Toronto, ON M4Y 2G1

Oncidium
clarity when you need it

Manulife

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your employer and your physician(s).

We ask you to provide information about what you are capable and incapable of doing, in relation to your job demands.

We ask your employer to tell us about your job demands.

We ask your physicians to provide us with information about your restrictions and limitations.

You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.

All of the above information will be reviewed to determine whether you meet the eligibility criteria and that review cannot be completed until all of the information has been received. In some cases, it may be necessary to gather additional information before a decision can be made. We will notify you if this becomes necessary.

Important notice

The Pension Office Corporation of The Anglican Church of Canada is responsible for the administration of long term disability (LTD) claims. The Pension Office has partnered with Workplace Health and Cost Solutions Ltd. (operating as Oncidium) to assess and manage long-term disability (LTD) claims during the first 22 months of disability. The Pension Office Corporation has also engaged Manulife to provide disability coverage and manage claims where a member remains disabled beyond 22 months, at which time the LTD claim would be transitioned to Manulife.

How this claim will be assessed and managed

- For the first 22 months that a plan member is considered disabled, Oncidium assesses and manages the claim and any payments are the responsibility of The Pension Office Corporation.
- If the plan member continues to be disabled beyond 22 months, Manulife will then become the disability insurer and take over management of the claim. While Manulife, The Pension Office and Oncidium work in partnership throughout a disability, the transition of the claim to Manulife will start approximately 2 months prior to the expected transition date to ensure the seamless transition of the claim. Only if the disability extends beyond 22 months will Manulife be responsible as disability insurer.
- The goal of the claim management process is to ensure that claims are assessed in a timely manner and that those plan members who possess the potential to return to work receive support and assistance in returning to part-time or full-time employment.
- By working together, the number of forms that plan members need to complete is reduced. For example, this form is the only initial disability claim form a plan member needs to complete. Those plan members who will transition to Manulife will not need to complete another form specifically for this transition. Oncidium will simply transfer the information they have to Manulife at the appropriate time.
- In order to ensure confidentiality of personal information, The Pension Office Corporation and Oncidium (and as applicable Manulife) will each establish a disability claim file in which information concerning all of your disability claims will be kept. Only employees or authorized agents of The Pension Office Corporation, Oncidium or Manulife who are responsible for the management of your claim shall have access to the files.
- Plan members can be confident that whether they are dealing with The Pension Office, Oncidium or Manulife, experienced disability professionals and administrators will provide superior service and expert claims management on each and every claim submitted to The Anglican Church of Canada LTD Plan.

Instructions

1. Please complete the "Plan Member Statement" section.
2. Please ensure that the Employer completes the "Employer Statement" section.
3. Please ensure that your physician completes the "Attending Physician's Statement". Please ensure that you complete the Patient Authorization section of the "Attending Physician's Statement" prior to providing it to your physician.
4. Please note that any costs incurred in the completion of the "Attending Physician's Statement" are your responsibility.
5. Please ensure that all of the above-mentioned forms are submitted on a timely basis, sending them in together in order to avoid unnecessary delays in the assessment of your claim.
6. Please note that Long Term Disability (LTD) benefits are reduced by certain benefit payments including those made by CPP/QPP (disability) and Worker's Compensation. It is the responsibility of the employee to repay any overpayments that occur as a result of eligibility for these types of benefits for periods in which LTD was also paid.

Oncidium clarity when you need it

Manulife

Group Benefits
Plan Member Statement
Long Term Disability Claim

Additional information may be submitted on separate pages if there is insufficient space on this form.

Executive Director
Pension Office Corporation
625 Church Street, Suite 401
Toronto, ON M4Y 2G1

1 Plan member information

You can obtain your plan number, division number, and your plan member certificate number from your benefit card.

Plan contract number	Plan sponsor's name
5640	**The Anglican Church of Canada**

Division number	Plan member certificate number	Job title

SIN	Date of birth (dd/mmm/yyyy)

Full name (last, first, initial)

◯ Mr. ◯ Ms. ◯ Other _____
◯ Miss ◯ Mrs.

Street address (number, street and apartment)

City	Province	Postal code

Phone number	Fax number	Height	Weight

Mailing address (if different from above)

2 Work information

a) Last day worked? (dd/mmm/yyyy)

b) Prior to stopping work had your job been modified? ◯ Yes ◯ No *If yes, how was it modified?*

c) If your work was modified, why were you unable to continue working?

d) How long were you performing modified work?

e) Since work absence commenced:

Have you done any work for pay?	Dates (dd/mmm/yyyy) (from - to)	Describe
◯ Yes ◯ No		

3 Other activities information

Since work absence commenced:

Have you returned to school/retraining?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

Have you done volunteer activity?	Dates (dd/mmm/yyyy)	Describe
◯ Yes ◯ No		

4 Injury information

a) Is work absence due to an injury? ◯ Yes ◯ No *If no, please go to section 6, Illness information.*

b) What kind of injury? ◯ Motor vehicle accident ◯ Work related ◯ Other _____

c) Describe how and when injury occurred.

Date of injury (dd/mmm/yyyy)	Time of injury ◯ am ◯ pm

d) Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide lawyer's name and address.*

Lawyer's name	Lawyer's address
Phone number	

e) Was the occurrence investigated by police? ◯ Yes ◯ No *If yes, please provide a copy of the police report.*

5 Motor vehicle accident information

a) If your work absence is related to a motor vehicle accident, please provide the following information:

Your insurer's name	Your insurance adjuster's name and phone number
Your insurance policy number or claim number	

6 Illness information

a) Have you ever had the same or a similar illness? ◯ Yes ◯ No *If yes, state when and describe.*

b) Did the illness result in an absence from work? ◯ Yes ◯ No *If yes, state when.*

From (dd/mmm/yyyy)	To (dd/mmm/yyyy)

c) Describe your current condition, including how it prevents you from working.

7 Medical information

a) Please provide the following information about the family doctor who has your MEDICAL RECORDS.

Last name of doctor	First name of doctor	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)
Address of doctor (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	

b) Please provide the following information about ANY OTHER SPECIALIST OR HEALTH CARE PRACTITIONER you have seen or are scheduled to see for this condition. (e.g. chiropractor, physiotherapist, psychologist, etc.)

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	

Last name	First name	Approximately when did you first seek attention for this condition?	(dd/mmm/yyyy)
Address (number and street)	Suite	Date of first visit (dd/mmm/yyyy)	Date of next visit (dd/mmm/yyyy)
City	Province	Frequency of visits	
Postal code	Telephone number	Type of practitioner	

8 Income/Benefit information

Have you received or are you receiving any of the following income/benefits.
If so, please provide copies of pay slips and/or award letters, including decline letters.

Receipt of any benefits, including the following may result in a reduction to the benefit you receive under the Long Term Disability Plan (LTD Plan) and may require reimbursement to the LTD Plan through The Pension Office and/or to Manulife of any benefit paid under this claim. It is imperative that you notify us of any change in the status of these benefits.

INCOME/ BENEFIT	DATE OF APPLICATION (dd/mmm/yyyy)	REFERENCE OR CLAIM NUMBER	CURRENT STATUS: *(Check all that apply)*				
			PENDING?	AWARDED?	DECLINED?	TERMINATED?	APPEALED?
QPP			◯	◯	◯	◯	◯
CPP			◯	◯	◯	◯	◯
Workers' compensation*			◯	◯	◯	◯	◯
Other group insurance			◯	◯	◯	◯	◯
Association plan			◯	◯	◯	◯	◯
Motor vehicle insurance			◯	◯	◯	◯	◯
Salary continuation			◯	◯	◯	◯	◯
Any short term plan			◯	◯	◯	◯	◯
Employment insurance			◯	◯	◯	◯	◯
Retirement - government			◯	◯	◯	◯	◯
Severance			◯	◯	◯	◯	◯
Employment			◯	◯	◯	◯	◯

**Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission de la santé et de la sécurité du travail (CSST).*

9 Summary of education, training and experience

Please attach a copy of a current résumé, if available. Otherwise, please provide the following information.

a) **Education**

SCHOOL	LOCATION	LEVEL OBTAINED	YEAR	AREA OF STUDY
Elementary school/ High school				
College or university				
Other (Please include all forms of upgrading, in-service training, training on the job, special interest courses, etc.)				

b) **Work experience**

Begin with most recent but include every job you have had in the last 15 years. If more space is required, please use additional sheets of paper.

DURATION OF EMPLOYMENT		EMPLOYER	JOB TITLE AND DUTIES
FROM	TO		

c) **Acquired skills**

If not already mentioned in the education section, these may include typing, operation of equipment, supervisory skills, special licenses or designations, etc. Where appropriate, give level, speed or proficiency.

10 Driver's licence information

a) Does your job require you to have a professional licence or designation? Please explain.

b) Do you have a valid driver's licence?

◯ Yes ◯ No

Class	Indicate any restrictions

11 Other interests

Hobbies and interests, including any volunteer work.

12 Work capacity evaluation

In this section we are gathering information about your job duties and your ability or inability to do them. Please indicate the extent that you are now able to perform each activity that your job requires. If you have indicated "UNABLE TO DO", please provide primary reason.

PHYSICAL ACTIVITIES

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)	UNABLE TO DO (Please explain)
Sitting	◯	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯	◯	◯
Bending/Squatting	◯	◯	◯	◯	◯	◯	◯
Crouching	◯	◯	◯	◯	◯	◯	◯
Crawling	◯	◯	◯	◯	◯	◯	◯
Pushing	◯	◯	◯	◯	◯	◯	◯
Pulling	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; fingers	◯	◯	◯	◯	◯	◯	◯
Simple grasping	◯	◯	◯	◯	◯	◯	◯
Fine manipulation	◯	◯	◯	◯	◯	◯	◯
Fine manipulation; hands	◯	◯	◯	◯	◯	◯	◯
Repetitive body motions	◯	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯	◯
Reaching - above shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - at shoulder level	◯	◯	◯	◯	◯	◯	◯
Reaching - below shoulder	◯	◯	◯	◯	◯	◯	◯
Reaching - side to side	◯	◯	◯	◯	◯	◯	◯
Reaching - up and down	◯	◯	◯	◯	◯	◯	◯

Activity	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY		
Lifting - floor to waist	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Lifting - waist to shoulder	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Lifting - above shoulder	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant
Carrying	◯	◯	◯	◯	◯	◯ Infrequent	◯ Frequent	◯ Constant

PHYSICAL

Are you able to work in any of the following conditions?	Yes	No	If *no*, please explain
Exposure to marked changes in temperatures and humidity	◯	◯	
Being around moving machinery	◯	◯	
Unprotected heights	◯	◯	
Exposure to dust, fumes and gases	◯	◯	
Driving automobile equipment	◯	◯	

In this section we are gathering information about your job duties and your ability or inability to do them. For each activity that your job requires of you, please indicate the extent to which you are able to do it. If you have indicated "UNABLE TO DO", please provide primary reason.

PSYCHOLOGICAL ACTIVITIES

A. Understanding and memory	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Remember locations and routine procedures	◯	◯	◯	◯	◯	◯	◯
Understand and remember short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Understand and remember detailed instructions	◯	◯	◯	◯	◯	◯	◯

B. Sustained concentration and persistence	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Carry out short and simple instructions	◯	◯	◯	◯	◯	◯	◯
Carry out detailed instructions	◯	◯	◯	◯	◯	◯	◯
Maintain attention and concentration for extended periods	◯	◯	◯	◯	◯	◯	◯
Perform activities within a schedule	◯	◯	◯	◯	◯	◯	◯
Sustain an ordinary routine without supervision	◯	◯	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯	◯	◯
Solve simple straightforward problems	◯	◯	◯	◯	◯	◯	◯
Solve complex problems	◯	◯	◯	◯	◯	◯	◯

C. Social interaction	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Interact with the general public	◯	◯	◯	◯	◯	◯	◯
Ask questions or request assistance	◯	◯	◯	◯	◯	◯	◯
Accept instructions and feedback	◯	◯	◯	◯	◯	◯	◯
Get along well with others without distracting them	◯	◯	◯	◯	◯	◯	◯
Get along well with others without being distracted by them	◯	◯	◯	◯	◯	◯	◯

D. Adaptation	N/A	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT	UNABLE TO DO (Please explain)
Respond to frequent changes in the environment or tasks	◯	◯	◯	◯	◯	◯	◯
Aware of normal hazards and take appropriate precautions	◯	◯	◯	◯	◯	◯	◯
Travel in unfamiliar places or use public transportation	◯	◯	◯	◯	◯	◯	◯
Set realistic goals or make plans independently of others	◯	◯	◯	◯	◯	◯	◯
Juggle tasks and prioritize	◯	◯	◯	◯	◯	◯	◯

E. Responsibility and accountability	Yes	No
Is work pace without the pressure of deadlines?	◯	◯
Does the work involve occasional pressure to meet deadlines?	◯	◯
Does the work involve periodic pressure to meet deadlines?	◯	◯
Does the work involve significant pressures?	◯	◯

13 Other information

Please provide any additional information that you believe should be considered in assessing your claim.

14 Agreement, authorization and certification

I confirm that:

- I have read and understood the notice on page 1 of this claim form that explains the claim assessment and management process.
- The information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- My claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) will investigate my claim(s) and will require personal information about me, which may include information regarding my activities, income, employment, education, training, health, and medical history and treatment, including clinical notes.
- I will participate and cooperate with the disability management process and remain available for work and will perform modified work, as I am medically able.
- A photocopy or electronic version of this authorization shall be as valid as the original.
- I understand that more specific details regarding how and why The Pension Office Corporation, Oncidium and Manulife collect, use, maintain, and disclose my personal information can be found in their respective privacy policies, available on their websites or at www.anglicanpension.ca, www.oncidium.com and www.manulife.ca respectively.

I authorize:

- The Pension Office Corporation and Oncidium (and as applicable Manulife) and their respective service providers, any person or organization who has personal information about me, including any employer, group plan administrator, plan sponsor, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer and administrator of government benefits or other benefits programs, to exchange my personal information with each other for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claims, including independent medical assessments.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) and their reinsurers and service providers to collect, use, maintain and disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, assessment, investigation and management, including independent medical assessments, and to hold discussions with each other about my claims for such purposes. For clarity, I authorize Oncidium (and as applicable Manulife) to release to various independent medical providers and their assessment teams, all relevant information including medical documentation relating to my medical condition and treatment plan and to forward a copy of my independent medical report(s) to my physician.
- The Pension Office Corporation and Oncidium (and as applicable Manulife) to release information to my Employer or a third party advisor of my Employer for plan administration and analysis purposes only and I acknowledge that my medical information will not be provided to my Employer unless my consent is explicitly obtained.
- Oncidium (and as applicable Manulife), should a return to work be possible, to share with my employer a functional case summary which includes information such as restrictions, limitations and modifications necessary for return to work.
- The Pension Office Corporation (and as applicable Manulife) to use my SIN for the purposes of tax reporting and my member certificate number will be used as an identifier for all other purposes.
- The transfer of my claim file to Manulife in the event that my disability continues beyond a period of 22 months.

I acknowledge that:

- Oncidium reserves the right to undertake an independent medical examination and/or medical assessment/ functional evaluation with respect to my disabling condition during the first 22 months of disability and that nothing in this clause affects Manulife's contractual rights regarding assessments.
- Disability benefits from either the Canada Pension Plan or the Quebec Pension Plan are direct offsets from my LTD benefits and that I will ensure that these amounts will be reimbursed when received. I further acknowledge that benefits paid by Worker's compensation (WCB/WSIB/CSST) as a result of a work-related incident are also direct offsets from my LTD benefit and that I will ensure that these amounts will be reimbursed when received. In the event that an overpayment of benefits exists from the LTD Plan of The Anglican Church of Canada, I agree to repay the full amount owed in a lump sum or from my LTD benefits payable from The Pension Office Corporation or Manulife, whichever is applicable, until the overpayment is recovered in full.
- Any personal information provided to or collected by The Pension Office Corporation and Oncidium (and as applicable Manulife) in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of my personal information will be limited to employees, representatives, reinsurers, and service providers of The Pension Office Corporation and Oncidium (and as applicable Manulife) in the performance of their jobs, as well as persons to whom I have granted access or authorized disclosure 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.
- I may revoke my authorizations in this section at any time by sending written instructions to The Pension Office Corporation, Oncidium or Manulife, each as applicable.

Plan member's signature	Date signed (dd/mmm/yyyy)

Oncidium clarity when you need it

Manulife

Group Benefits Employer Statement
Long Term Disability Claim

Executive Director
Pension Office Corporation
625 Church Street, Suite 401
Toronto, ON M4Y 2G1

1 Employer

Plan contract number	Plan sponsor's name
5640	**The Anglican Church of Canada**

Name of employer/diocese

Address	Province	Postal code

Contact	Title	Phone number	Fax number

Plan sponsor contribution to premiums
LTD _____ %

2 Plan member identification

Name (last, first, initial)

◯ Mr. ◯ Ms. ◯ Other _____
◯ Miss ◯ Mrs.

Plan member certificate number	Class	Division number	Date of birth (dd/mmm/yyyy)

3 Coverage information

a) What were the plan member's work hours?

◯ Full-time HRS/WK_____ ◯ Part-time HRS/WK_____ ◯ Other HRS/WK_____

b) What was the employment status prior to the disability date?

◯ Actively employed *OR* ◯ Leave of absence ◯ Disability leave ◯ On layoff ◯ Pensioned ◯ Terminated

Please provide effective date (dd/mmm/yyyy)

4 Work schedule information

a) What was the date last worked and the next scheduled work date?

Date last worked (dd/mmm/yyyy)	Next scheduled work date (dd/mmm/yyyy)

b) List any dates plan member worked during the 119 day Qualifying Period.

c) What is the return to work date?

Return to work date (dd/mmm/yyyy)

◯ Actual ◯ Expected ◯ Unknown

5 Plan member's earnings and benefit information

a) What was the salary (for pension purposes) when the plan member was last at work?

b) Other Income? (if applicable)

*Please provide the following information, **OR** a copy of the current payslip.*

Salary (for pension purposes)
$

Other income
$
(Overtime, bonus, shift differential as per policy provisions)

PAYMENT SCHEDULE

◯ Hourly ◯ Weekly ◯ Bi-weekly ◯ Semi-monthly ◯ Monthly ◯ Annual

◯ Hourly ◯ Weekly ◯ Bi-weekly ◯ Semi-monthly ◯ Monthly ◯ Annual

5 Plan member's earnings and benefit information (continued)

c) What is the date of the last salary increase?

Date of last salary increase (dd/mmm/yyyy)

d) Personal income tax exemptions

Federal income tax	Provincial income tax
$	$

e) Does employee reside in a rectory?

◯ Yes ◯ No

6 Additional earnings

a) Please indicate if any of the following have been paid (or are payable) since date plan member last worked.

	PAID/PAYABLE	AMOUNT	PERIOD	
Salary continuance	◯ Yes ◯ No	$	To	From
Sick leave	◯ Yes ◯ No	$	To	From
Vacation pay	◯ Yes ◯ No	$	To	From
Short Term disability	◯ Yes ◯ No	$	To	From
Severance	◯ Yes ◯ No	$	To	From
Other	◯ Yes ◯ No	$	To	From

7 Workers' compensation information

a) Is the current disability due to a work related accident or illness?

◯ Yes ◯ No *If yes, has a claim been filed with the appropriate board?* ◯ Yes ◯ No

b) Please provide a copy of the Accident/Illness report and:

Workers' compensation board contact name	Phone number	Fax number

Claim number	Date benefit commenced (dd/mmm/yyyy)	Date benefit ceased (dd/mmm/yyyy)

c) What is/was the benefit amount?

Benefit amount
$

◯ Weekly ◯ Bi-weekly ◯ Monthly

d) Is the plan member receiving any other type of workers' compensation income?

◯ Yes ◯ No

Permanent award $	Effective date (dd/mmm/yyyy)
Workers' compensation board supplements $	Effective date (dd/mmm/yyyy)
Lump sum settlement $	Payment period

e) If WCB benefits were denied or terminated has plan member appealed this decision?

◯ Yes ◯ No *If yes, date of appeal* (dd/mmm/yyyy)

8 Return to work contact

What is the name, job title and phone number of the person in your organization we should contact to facilitate a return to work once this plan member's abilities and limitations are known?

Name	Job title	Phone number

9 Modified/Alternate work

◯ Yes ◯ No

a) If the plan member could return to work, would modified duties or alternate work be available?

If yes, please provide details

b) Has this been discussed with the plan member?

◯ Yes ◯ No

10 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

Please attach any medical or other information provided to or obtained by you, relative to the plan member's absence.

11 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Employer's signature	Title

Employer's phone number	Date (dd/mmm/yyyy)

The information in this statement will be kept in a disability benefits file with The Pension Office, Oncidium (and as applicable Manulife) and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any contained herein.

Note: Please see next page and ensure the remainder of this form is completed.

Please ensure that the remainder of this form is completed by the plan member's supervisor.

Sections 12 - 16 may be separated from the rest of the form, if necessary.

12 Plan member identification

Please provide this information again if you plan to separate sections 12 to 16 for the plan member's supervisor to complete.

Plan contract number
5640

Name (last, first, initial)

◯ Mr. ◯ Ms. ◯ Other _____
◯ Miss ◯ Mrs.

Plan member certificate number

Class

Division number

13 Work information

THIS SECTION TO BE COMPLETED BY THE PLAN MEMBER'S IMMEDIATE SUPERVISOR.
Please enclose a detailed job description for the plan member. The description must be for the job the plan member was performing immediately prior to the date last worked.

a) What was the plan member's job title as of the last day worked?

Job title

b) How long has the plan member held this position?

Position held
years months

c) How long is the plan member's usual work day?

Length of plan member's work day

d) What is the usual work pattern? (i.e. number of shifts worked per week)

Plan member's usual work pattern

e) What are the primary duties of the plan member's job?

PRIMARY DUTIES	TIMES	**OR**	HOURS PER DAY

f) Please list any office machines, tools or other equipment that the plan member uses in this job.

TYPE OF EQUIPMENT	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯

14 Job requirements

a) In this section we are gathering information about the plan member's specific physical or psychological job tasks. If you have a physical or psychological demands analysis, please provide it, **OR** complete the following section as applicable.

PHYSICAL DEMANDS OF JOB

Activity	N/A	SELDOM (< 1 hr.)	INFREQUENT (1 - 2 hrs.)	OCCASIONAL (2 - 4 hrs.)	FREQUENT (4 - 6 hrs.)	CONSTANT (> 6 hrs.)
Sitting	◯	◯	◯	◯	◯	◯
Standing	◯	◯	◯	◯	◯	◯
Walking	◯	◯	◯	◯	◯	◯
Climbing	◯	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯	◯
Bending/Squatting	◯	◯	◯	◯	◯	◯
Crouching	◯	◯	◯	◯	◯	◯
Crawling	◯	◯	◯	◯	◯	◯
Pushing	◯	◯	◯	◯	◯	◯
Pulling	◯	◯	◯	◯	◯	◯
Fine manipulation; fingers	◯	◯	◯	◯	◯	◯
Simple grasping	◯	◯	◯	◯	◯	◯
Fine manipulation	◯	◯	◯	◯	◯	◯
Fine manipulation; hands	◯	◯	◯	◯	◯	◯
Repetitive body motions	◯	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯	◯
Reaching - above shoulder	◯	◯	◯	◯	◯	◯
Reaching - at shoulder level	◯	◯	◯	◯	◯	◯
Reaching - below shoulder	◯	◯	◯	◯	◯	◯
Reaching - side to side	◯	◯	◯	◯	◯	◯
Reaching - up and down	◯	◯	◯	◯	◯	◯

Lifting / Carrying	N/A	0 - 10 lbs	11 - 20 lbs	21 - 50 lbs	> 50 lbs	FREQUENCY
Lifting - floor to waist	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - waist to shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Lifting - above shoulder	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant
Carrying	◯	◯	◯	◯	◯	◯ Infrequent ◯ Frequent ◯ Constant

Are assistive devices ◯ utilized ◯ available ◯ N/A

Is your plan member required to work in any of the following conditions?	Yes	No
Exposure to marked changes in temperatures and humidity	◯	◯
Being around moving machinery	◯	◯
Unprotected heights	◯	◯
Exposure to dust, fumes and gases	◯	◯
Driving automobile equipment	◯	◯
Is the plan member able to change position as comfort requires?	◯	◯

Which of the following categories best describes the psychological demands of your plan member's job?

PSYCHOLOGICAL DEMANDS OF JOB

A. Understanding and memory	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Remember locations and routine procedures	◯	◯	◯	◯	◯
Understand and remember short and simple instructions	◯	◯	◯	◯	◯
Understand and remember detailed instructions	◯	◯	◯	◯	◯

B. Sustained concentration and persistence	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Carry out short and simple instructions	◯	◯	◯	◯	◯
Carry out detailed instructions	◯	◯	◯	◯	◯
Maintain attention and concentration for extended periods	◯	◯	◯	◯	◯
Perform activities within a schedule	◯	◯	◯	◯	◯
Sustain an ordinary routine without supervision	◯	◯	◯	◯	◯
Make simple decisions	◯	◯	◯	◯	◯
Solve simple straightforward problems	◯	◯	◯	◯	◯
Solve complex problems	◯	◯	◯	◯	◯

C. Social interaction	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Interact with the general public	◯	◯	◯	◯	◯
Ask questions or request assistance	◯	◯	◯	◯	◯
Accept instructions and feedback	◯	◯	◯	◯	◯
Get along well with others without distracting them	◯	◯	◯	◯	◯
Get along well with others without being distracted by them	◯	◯	◯	◯	◯

D. Adaptation	SELDOM	INFREQUENT	OCCASIONAL	FREQUENT	CONSTANT
Respond to frequent changes in the environment or tasks	◯	◯	◯	◯	◯
Aware of normal hazards and take appropriate precautions	◯	◯	◯	◯	◯
Travel in unfamiliar places or use public transportation	◯	◯	◯	◯	◯
Set realistic goals or make plans independently of others	◯	◯	◯	◯	◯
Juggle tasks and prioritize	◯	◯	◯	◯	◯

E. Responsibility and accountability	Yes	No
Is work pace without the pressure of deadlines?	◯	◯
Does the work involve occasional pressure to meet deadlines?	◯	◯
Does the work involve periodic pressure to meet deadlines?	◯	◯
Does the work involve significant pressures?	◯	◯

b) Before the plan member stopped working, did the illness or injury cause him/her to change:

		Date (dd/mmm/yyyy)	Explanation
Job duties	◯ Yes ◯ No		
Job performance	◯ Yes ◯ No		
Equipment	◯ Yes ◯ No		
Environment	◯ Yes ◯ No		
Hours of work	◯ Yes ◯ No		
Attendance	◯ Yes ◯ No		

15 Other information

Please provide any additional information that you believe should be considered in assessing this plan member's claim.

16 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Authorized signature	Title

Telephone	Date (dd/mmm/yyyy)

The information in this statement will be kept in a disability benefits file with The Pension Office, Oncidium (and as applicable Manulife) and might be accessible by the plan member or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any contained herein.

Group Benefits
Initial Attending Physician's Statement
Long Term Disability Claim

Executive Director
Pension Office Corporation
625 Church Street, Suite 401
Toronto, ON M4Y 2G1

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Plan contract number	Plan member certificate number
	5640	

"I hereby authorize the release to The Pension Office, Oncidium (and as applicable Manulife) of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. **I understand that I am responsible for any fees related to the completion of this form.**"

Patient's signature	Date (dd/mmm/yyyy)

2 Attending physician's statement

Diagnosis

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) ***If*** psychiatric disorder, provide current GAF score.

GAF score

d) ***If*** cardiac disorder, provide American Heart Association functional classification.

◯ Class I (No limitation) ◯ Class II (Slight limitation)
◯ Class III (Marked limitation) ◯ Class IV (Complete limitation)

3 Clinical information

Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results in support of your patient's diagnosis and functional abilities.

a) What date did symptoms first appear/accident happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

◯ Injury ◯ Work-related ◯ Motor vehicle accident ◯ Other (specify)
◯ Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)	Date of latest visit (dd/mmm/yyyy)

Frequency of visits

◯ Weekly ◯ Bi-weekly ◯ Monthly ◯ Other (specify)

e) What are the patient's subjective ***symptoms***?

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity)

g) What were your initial ***clinical findings***?

h) What are your most recent ***clinical findings***?

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

◯ Ambulatory
◯ Ambulatory with assistive devices
◯ Bed confined
◯ Home confined
◯ Hospital confined

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand
		◯ Left ◯ Right

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)

m) ***If*** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD OS	Without corrective lenses OD OS	Date of last exam (dd/mmm/yyyy)

n) ***If*** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

◯ Recovered
◯ Improved
◯ No change
◯ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

◯ Yes ◯ No

If no, please elaborate:

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

◯ Yes ◯ No

If no, from what date?

Date (dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

◯ Yes ◯ No

◯ Restricted ◯ Suspended ◯ Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.

Name of attending physician (please print)

Specialty	Telephone (include area code)	Fax (include area code)

Address (number, street and apartment)

City	Province	Postal code

Signature	Date signed (dd/mmm/yyyy)

Print

The information in this statement will be kept in a disability benefits file with The Pension Office, Oncidium (and as applicable Manulife) and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.