Questions for Doctor to Answer:

1. Have you seen the patient? When?

2. Did you exam the patient? Did you perform any tests? What tests? Please provide the results?

3. What is/are the medical diagnosis/ses?

4. Is the patient under your care? Will the patient continue to be under your care? For how long?

5. Have you recommended a treatment plan? What is the plan? Is the patient following the treatment plan?

6. Have you read the patient's job duties and responsibilities? See attached.

7. Is the patient able to perform any of these duties and responsibilities? If yes, which ones? Does the patient have any restrictions? Does the patient require any accommodation?

8. If the patient is unable to perform any of these duties and responsibilities, what is the prognosis for a return to work, with or without restrictions and/or accommodation?

CANADA POST POSTES CANADA
From anywhere... to anyone

Employee Statement

Short-Term Disability Claim

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for disability benefits under the Canada Post Short-Term Disability Program. A completed claim form must be returned within 14 days of the start of the disability to avoid interuptions in payments. The completed form should be mailed or faxed directly to:

MANULIFE FINANCIAL
2 QUEEN ST
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Telephone: 1-866-232-9674 or (613) 369-2000
Fax: 1-866-232-9642 or (613) 233-8233

This form is not to be used for workplace injuries/illnesses.
Ask your team leader instead to provide you with the appropriate WCB form.

SECTION A Employee information (please print)

Employee name (Last, First, Middle initial):	☐ Mr. ☐ Ms.
Full address (Street, City, Province, Postal Code):	
Employee ID#	E-mail:
Home phone #	Alternate phone #
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):

SECTION B Information about your work (please print)

Last day worked (dd/mm/yyyy): First day of absence (dd/mm/yyyy): When do you expect to return to work:	☐ Full-Time ☐ Part-Time ☐ Term Employee greater than 6 months	Team Leader's Name: Telephone #:
Job title:	Describe your job duties:	

SECTION C Information about your claim (please print)

Is your disability the result of: ☐ non-work related illness? ☐ non-work related accident? ☐ motor vehicle accident?

Describe your illness or injury:

Have you had a similar or related condition? ☐ **No** ☐ **Yes** If yes, how long ago (if applicable):

Are you able to return to work on modified duties?

Date and time of accident (If applicable):	Are you seeking reimbursement from a third party? ☐ **No** ☐ **Yes**

Briefly describe how and where the accident happened:

Hospitalized? ☐ **No** ☐ **Yes** Name of Institution:

Name of ward/unit:

Date admitted (dd/mm/yyyy): Date discharged (dd/mm/yyyy):

SECTION D Income or benefit Information (please print)

Income / Benefit information		Start date	End date	Amount (indicate per week or monthly)
Have you applied for or are you receiving any of the following:	Employment Insurance			
	Benefits payable under any type of Worker's Compensation Board program (WCB / WSIB / CSST)			
	Benefits payable from Motor Vehicle Insurance or other insurance			
	Earnings from other employment			
	Other			
	Note: For the duration of your claim, it is your responsibility to notify Manulife Financial of any work performed, whether or not you have received any wage or remuneration; and any employment income paid to you as a result of work performed by you.			

Are you following the recommended treatment program? ☐ **No** ☐ **Yes**

Name of primary attending physician/Healthcare practitioner:

Specialty:

Date first treated:

Address:

Telephone #

Canada Post is subject to the Privacy Act and is committed to protecting employee personal information and managing this information with utmost responsibility and care.

You can be sure that any medical information you give to our disability-management providers will be kept strictly confidential and protected from improper and unauthorized use, disclosure, retention and disposal.

I certify that the information on this form is true and complete, to the best of my knowledge. I understand that my claim may be denied or terminated as a result of my providing false, or misleading information, or omitting pertinent information.

I authorize my doctor, Manulife Financial and its agents and service providers and any person or organization who has relevant personal information about me, including health professionals and organizations, to exchange information for the purpose of determining eligibility for and the adjudication of my claim. This includes the release of any related medical information, including but not limited to copies of all consultation reports, clinical notes, test results and hospital records.

I authorize Manulife Financial and Canada Post to exchange information about me except for details relating to diagnosis, treatment or medication relevant to this claim for the purpose of planning and managing my rehabilitation and return to work and for administration of the Short-Term Disability Plan.

I agree that a photocopy of this authorization shall be as valid as the original.

I agree to reimburse Canada Post for any Short-Term Disability plan overpayments.

Employee's signature:

Date (dd/mm/yyyy):

Attending Physician's Statement

Short-Term Disability Claim

Please complete this form as soon as possible to expedite the processing of your patient's claim for disability benefits under the Canada Post Short-Term Disability Program. It should be completed and returned within 14 days from the onset of the disability to avoid interruptions of payment to the employee. The completed form should be mailed or faxed directly to:

MANULIFE FINANCIAL
2 QUEEN ST
PO BOX 4606 STN A
TORONTO ON M5W 4Z2
Telephone: 1-866-232-9674 or 613 369-2000
Fax: 1-866-232-9642 or 613 233-8233

This form is not to be used for workplace injuries/illnesses.

SECTION A | **To be completed by patient (please print)**

Employee Name (Last, First, Middle initial):

Employee ID#	E-mail:
Home Phone #	Alternate Phone #

Address (number, street, city, province, postal code):

Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):	Date form provided to Physician (dd/mm/yyyy):

I hereby authorize the release of information held in my file by the physician named below to Manulife Financial and its agents and service providers for the purpose of assessing my claim and administering the disability plan regarding this claim. This medical information includes, but is not limited to copies of consultation reports, clinical notes, test results and hospital records supporting this claim. **I understand that I am responsible for any costs related to the completion of this form.**

Employee's signature: Date (dd/mm/yyyy):

SECTION B | **To be completed by the attending physician (please print)**

Diagnosis(es) or working diagnosis(es): If psychological, please provide DSM IV Axis 1 diagnosis and GAF score. GAF score (if applicable):	Primary Diagnosis: Secondary Diagnosis:	If childbirth: expected or actual delivery date (dd/mm/yyyy):

Is the diagnosed disability the result of: ☐ Non-Occupational illness? ☐ Non-Occupational accident?

Has the patient had a similar or related condition? ☐ **No** ☐ **Yes** If yes, state when and describe condition:

Is the condition considered to be chronic? ☐ **No** ☐ **Yes** If yes, what precipitated the absence from work?

Date of first visit (dd/mm/yyyy): Date of last visit (dd/mm/yyyy):	Date first unable to work due to present condition(s) (dd/mm/yyyy): Expected date of return to work (dd/mm/yyyy):
Admitted to hospital? ☐ **No** ☐ **Yes** Date Admitted (dd/mm/yyyy):	Name of Institution: Hospital department/ward admitted to: Date Discharged (dd/mm/yyyy):

Treatment (current medication, types of drug(s), dosage and duration, physiotherapy, other):

SECTION C | **Physician's Acknowledgement and Authorization (please print)**

I acknowledge that the information in this statement will be kept in a health file with Manulife Financial and may be accessed by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Address (number, street, city, province, postal code):	Telephone number: Fax number:
Signature:	Date signed (dd/mm/yyyy):

NOTE TO PHYSICIAN: If the disability is anticipated to be resolved within two weeks of its onset, no further information is required. If not, please complete section D.

SECTION D — Additional information for absences known/expected to exceed two weeks (please print)

Describe the employee's condition in terms of symptomology (severity and frequency), objective findings and impact on activities of daily living.

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other___________________________

Patient's Height:___________________________ Patient's Weight:___________________________

Is complete recovery expected? ☐ **No** ☐ **Yes,** anticipated period of recovery ___________________________

Please describe any factors that may affect this patient's ability to return to work.

Please attach copies of all relevant test results/investigations and consultation reports (if test results are not attached, it will be assumed that tests were not performed).
If a consultation report is not attached please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist: Specialty: Date of Visit:

Please list any complications and additional condition(s) impacting your patient's level of function or the expected recovery period.

Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Physical impairment

Does your patient have a physical impairment?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Based on your assessment please describe your patient's current abilities in the following areas:

Lifting (max. weight/frequency)		Sitting (how long/frequency)	
Carrying (max. weight/distance)		Standing (how long/frequency)	
Pushing/Pulling (max. weight/frequency)		Walking (distance/frequency)	
Walking on uneven ground (distance/frequency)		Climbing (how long/frequency)	
Working at heights (distance/frequency)		Crawling (duration/frequency)	

Remarks:

Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

☐ **No** ☐ **Yes**

If yes, please complete this section.

Indicate if patient currently has cognitive/mental restrictions in the following areas:

	None	Mild	Moderate	Severe
Concentration (e.g., attention, orientation)				
Analytical reasoning (e.g., judgment)				
Learning new material (e.g., memory)				
Comprehension				
Social interaction (e.g., mood)				
Ability to multi-task				

In your opinion, is your patient competent to manage his/her own affairs? ☐ **No** ☐ **Yes**

Remarks:

Rehabilitation / Work re-entry

Has your patient expressed a desire to return to work? ☐ **No** ☐ **Yes**

Expected date of return to work to full duties (dd/mm/yyyy):

Please provide details about return-to-work plans for the patient:

To your knowledge is the patient following the recommended treatment program? ☐ **No** ☐ **Yes**

Has your patient's professional license certification, driver's or other license been restricted, suspended or revoked? ☐ **No** ☐ **Yes**

Physician Signature:

Date signed (dd/mm/yyyy):