Manulife Financial

Weekly Indemnity Benefit (WIB) Claim for Unionized Employees of Canadian Pacific Railway

- **Employee Statement**
- **Employer Statement**
- **Attending Physician's Statement**

An incomplete form may result in delays in the adjudication of the employee's disability claim.

Please see page 2 for instructions.

Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits

Weekly Indemnity Benefit (WIB) Claim for Unionized Employees of Canadian Pacific Railway

Applying for Weekly Indemnity Benefits (WIB)

1) Advise your supervisor that you will be off work for a non-work related illness or injury and for approximately how long you will be away. You **do not** need to advise as to the nature of the illness or injury.

2) Obtain a Manulife WIB Form from:
   a) your immediate supervisor;
   b) the Manulife website at: www.manulife.ca/groupbenefits;
   c) or RailTown at: http://railtown.cpr.ca/IntraEnglish/Employee+Services/Canadian+Union/Employee+-+Manager+HR+Forms/Other+Forms/Manulife.htm.

3) The WIB form has **three parts:**
   a) **Employee Statement** – complete this portion **immediately** and mail or fax it directly to Manulife as indicated on the form, and mail or fax a copy to your Time Administrator at CP (you should ask your supervisor for the appropriate address or fax number).
   b) **Employer Statement** – You do not have to submit this portion. Once your Time Administrator receives your Employee Statement, they will complete the Employer Statement and submit both to Manulife.
   c) **Physician's Statement** – fill out and sign section 1 and section 2 of the form and then you **must** have your Doctor complete this form as soon as possible as no payments can be made until Manulife receives and reviews this portion of the form. **Have your doctor fax it directly to Manulife at: 1-519-744-4519.**
      i) If you are a member of the **TC Local 1976 USW, CAW,** or **TCRC/MWED** unions, any fee for the completion of the Physician's Statement will be reimbursed by the Company. You need to submit an **original receipt** along with a completed MEDICAL FORM REIMBURSEMENT REQUEST form (attached) to the nearest location indicated on the bottom of the form.

4) **IMPORTANT - All three parts of the WIB Claim Form must be completed and submitted to Manulife as soon as possible. The Employee Statement must be received by Manulife within 30 days of the onset of disability, or your claim will be declined.**

5) Once Manulife receives **all three parts of the WIB form**, they may: accept the claim immediately; ask your doctor for more information; or advise you directly that the claim has not been accepted.

6) Once your claim is accepted, your WIB payments will be deposited directly into your bank account according to your union negotiated benefit plan.

7) As long as the medical information provided to Manulife warrants your inability to return to work, you will continue to receive WIB, **up to a maximum of 41 weeks**.

8) **WIB is set up in three stages**:
   a) For an initial **15 weeks**, you receive **WIB**.
   b) The next **15 weeks**, you may receive **Employment Insurance (EI) Sickness Benefits**.
      i) You will receive a **Record of Employment** (ROE) from the Company. Once you have **been off work for 13 weeks, you must apply for EI Sickness Benefits** with Service Canada Centre (SCC). Check the Blue Pages of your phone book for the nearest location.
      ii) You **must** immediately provide Manulife with the letter you receive from the SCC notifying you that your EI Sickness Benefits have either been accepted or declined.
      iii) If you are accepted, you **must** also forward any payment slips from the SCC directly to Manulife and you will be provided with a Top-up payment when applicable.
   c) Once your EI Sickness Benefits expire, or if you are not accepted for EI Sickness Benefits, you may receive an additional **11 weeks** of WIB.

9) **You must immediately notify your Case Manager at Manulife and your supervisor or Time Administrator when you return to work in any capacity!**

10) **Employees who have been off work for more than 21 days must have approval from OHS prior to returning to work. If you have any questions about returning to work, you can contact OHS at 1-866-876-0879.**

CANADIAN PACIFIC RAILWAY

MEDICAL FORM REIMBURSEMENT REQUEST – TCRC/MWED, TC Local 1976 USW, CAW

Original receipt must be attached to this form and send to the Human Resources Center.

Employee information

Name of employee	Employee number

Amount	Reason
$	

Authorization

Name supervisor	Title of supervisor

Signature of supervisor	Date (dd/mmm/yyyy)

Mailing instructions

Send to the Human Resources Centre.

Employee Services
Suite 400, Windsor Station
Canadian Pacific Railway
PO BOX 6042 STN CENTRE VILLE
MONTREAL QC H3C 3E4

Crew Dispatchers
CMC Payroll Scheduling
Canadian Pacific Railway
401 9 AVE SW
CALGARY AB T2P 4Z4

Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits
Employee Statement
Weekly Indemnity Benefit (WIB) Claim for Unionized Employees of Canadian Pacific Railway

- To be completed by the employee.
- Please print clearly and answer all questions.
- Additional statements may be submitted if there is insufficient space on this form.
- **You are responsible for any fees your doctor charges for completion of the Attending Physician's Statement form and photocopies of file documentation.**
- **This claim form must be completed and submitted within 30 days of the onset of disability.**

Return completed form to: **Manulife Financial Group Benefits**
Attention: Disability Claims
PO BOX 800 STN C, KITCHENER ON N2G 4Y5
Tel: 1-877-481-9169 Fax: (519) 744-4519

1 Employee information

You can obtain your plan number and your employee certificate number from your benefit card.

Plan contract number	Employee certificate number	Union
84500		

Employer's name	Job title	
Canadian Pacific Railway		◯ Safety sensitive ◯ Safety critical

Employee's full name (last, first, initial)	
	◯ Mr. ◯ Ms. ◯ Miss ◯ Mrs.

Birthdate (dd/mmm/yyyy)	Preferred language:	Height	Weight
	◯ English ◯ French		

Full address (number, street and apartment, P.O. Box number)		

City	Province	Postal code

Telephone number	Fax number	Number of dependants and ages
( )	( )	

2 Claim information

Last day worked (dd/mmm/yyyy)

Is your condition due to an accident? ◯ Yes ◯ No *If no, please go to section 3, Work information.*

What kind of accident?

◯ Motor vehicle accident ◯ Work related ◯ Other

Name of Motor Vehicle Accident Insurance carrier	Contact Person	Contact's telephone number
		( )

Describe how and when injury occurred	Date of accident (dd/mmm/yyyy)
	Time of accident ◯ a.m. ◯ p.m.

Is there any legal action involved? ◯ Yes ◯ No *If yes, please provide the following information:*

Lawyer's name	Telephone number
	( )

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

3 Work information

What are your job duties (e.g., operate machinery)?

When do you expect to return to your job? Date (dd/mmm/yyyy)

If you are still disabled after 15 weeks, you may be eligible to receive employment insurance (EI) sickness benefits for up to an additional 15 weeks while disabled. You must submit an application for EI Sickness benefit through your local Employment Insurance office when you reach week 14 of your weekly indemnity period. Sickness benefits payable under the EI Act are eligible for "top-up" to the WIB maximum amount (EI assessment must be provided to Manulife Financial).

4 Income/benefit information

Have you applied for 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.***

It is important that all sources of income be reported immediately. It is possible that these may impact potential benefit payment.

INCOME/ BENEFIT	REFERENCE OR CLAIM NO.	BENEFIT DATES (dd/mmm/yyyy) START	BENEFIT DATES (dd/mmm/yyyy) END	FREQUENCY WEEKLY	FREQUENCY BI-WEEKLY	FREQUENCY MONTHLY	FREQUENCY LUMP SUM	AMOUNT
Any type of workers' compensation board*				◯	◯	◯	◯	$
Motor Vehicle Insurance				◯	◯	◯	◯	$
Employment Insurance				◯	◯	◯	◯	$
Other				◯	◯	◯	◯	$

* 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).

5 Assignment, certification, and authorization

I certify that 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. **I agree** that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete, or misleading information.

I understand that Manulife Financial will investigate this claim and may require personal information about me, including information regarding my activities, income, employment, education and training, health, and medical history and treatment, including clinical notes. **I authorize** any person or organization who has personal information about me, including any employer, group plan administrator, health care professional, health care institution, pharmacy and any other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or other benefit programs, the Medical Information Bureau and investigative agency, to release my personal information to Manulife Financial and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments. **I authorize** Manulife Financial, its reinsurers and its service providers to collect, to use, to maintain and to disclose to the persons or organizations listed above and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, facilitating my return to work and for transitioning my claim to a long term disability claim.

This authorization shall remain valid for the duration of my claim for benefits or until revoked by me in writing. **I agree** that a photocopy or electronic version of this authorization shall be as valid as the original. **I acknowledge** that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy and Privacy Information Package, available at www.manulife.ca/groupbenefits, or from my Employer. **I understand** that any personal information provided to or collected by Manulife Financial in accordance with this authorization, will be kept in a group life, health, or disability benefits file. Access to my personal information will be limited to:

- Manulife Financial employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, to have any inaccurate information corrected.

Employee's signature	Date signed (dd/mmm/yyyy)
✘	

I authorize Manulife Financial and the Office of the Chief Medical Officer of Canadian Pacific to release to and/or exchange with each other, any personal information gathered through the claim adjudication and rehabilitation process including, but not limited to, my diagnosis, all medical information, consultation reports, independent medical reports, and hospital records for the purposes of facilitating my return to a work, including assessing my fitness for work and outlining recommendations for accommodation to my Supervisor. **I understand** only information related to my work restrictions will be transmitted to my Supervisor.

Employee's signature	Date signed (dd/mmm/yyyy)
✘	

Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits
Employer Statement
Weekly Indemnity Benefit (WIB) Claim for Unionized Employees of Canadian Pacific Railway

- To be completed by the employer.
- Please print clearly and answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this employee's claim.
- Provide the employee with an Employee Statement form and an Attending Physician's Statement form for the family physician or attending specialist. Ask the employee to complete the "Patient authorization" and "Medical information" sections at the top of the Attending Physician's Statement form on page 8 before they take it to their physician.

Return completed form to: **Manulife Financial Group Benefits**
Attention: Disability Claims
PO BOX 800 STN C, KITCHENER ON N2G 4Y5
Tel: 1-877-481-9169 Fax: (519) 744-4519

1 Employer

Plan contract number	Division number (Union)	Employer name
84500		**Canadian Pacific Railway**

Address (number, street, suite)

City	Province	Postal code

Contact name	Title	Telephone number	Fax number
		( )	( )

2 Employee identification

Name (last, first, initial) ◯ Male ◯ Female

Employee certificate number	Date of birth (dd/mmm/yyyy)

3 Employee information

Date of hire (dd/mmm/yyyy)	Date eligible for benefit (dd/mmm/yyyy)	Department

Employee's job title ◯ Safety sensitive ◯ Safety critical — Union affiliation of employee

Name of employee's supervisor/manager — Telephone number of supervisor/manager ( )

Date last worked (dd/mmm/yyyy)

Reason employee stopped working
◯ Illness ◯ Injury ◯ On layoff ◯ Leave of absence
◯ Dismissed ◯ Resigned ◯ Strike ◯ Other _____

Has the employee returned to work? ◯ Yes ◯ No

If yes, please provide date returned to work. (dd/mmm/yyyy) *If no, please provide expected return date.* (dd/mmm/yyyy)

Has coverage terminated? ◯ Yes ◯ No *If yes, please state when and reason why.*

Date coverage terminated (dd/mmm/yyyy)	Reason for termination of coverage

4 Employee's earnings and benefit information

It is important all sources of income be reported immediately. It is possible that these may impact potential benefit payment.

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

Weekly salary/wage when employee was last at work
$

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

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

Is employee on spare board, relief, or casual employment? ◯ Yes ◯ No ◯ Other _____

If yes, please attach a list of employee's earnings during the six (6) consecutive complete pay periods in which the employee received earnings immediately preceding disability. (Show clearly any vacation dates and the pay thereof. It may be necessary to go beyond six (6) periods to obtain six (6) periods in which payment was received.)

5 Tax information

Please complete as benefit is taxable.

*Please provide the following information, **OR** a completed TD1 or TP1 form.*

TD1	TP1	Employee's province of residence for income tax purposes

6 Additional earnings

Please indicate if any of the following have been paid.

INCOME/ BENEFIT	PAID/ PAYABLE		WEEKLY	PAID FROM (dd/mmm/yyyy)	PAID TO (dd/mmm/yyyy)	AMOUNT
	Yes	No				
Vacation pay	◯	◯	◯			$
Severance	◯	◯	◯			$
General holiday	◯	◯	◯			$
Retirement or pension	◯	◯	◯			$
Other	◯	◯	◯			$

7 Workers' compensation information

Please provide copy of information received from any type of workers' compensation board.

Is the current condition due to a work related accident or illness? ◯ Yes ◯ No

If yes, please explain.

8 Declaration

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

Authorized signature	Title

Telephone number	Date (dd/mmm/yyyy)
( )	

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial and might be accessible by the employee 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.

Manulife Financial

CANADIAN PACIFIC RAILWAY

Group Benefits
Attending Physician's Statement
Weekly Indemnity Benefit (WIB) Claim for Unionized Employees of Canadian Pacific Railway

The primary purpose of this statement is to assist Manulife Financial in making a decision about your patient's claim for disability benefits. The secondary purpose is to assist your patient in returning to work under the terms of CPR's Return To Work program. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife Financial to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE, OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. ***PLEASE KEEP A COPY FOR YOUR RECORDS.***

The primary goal of Canadian Pacific Railway's Return To Work Program is to assist employees who are absent from work due to medical reasons, to return to work and/or remain at work. This program includes modified or alternate duties for employees with temporary or permanent restrictions. Many positions occupied by Canadian Pacific Railway employees are critical to safe railway operations and impact on the safety of the public and/or other employees. Delay in processing of this claim may delay or prevent employees from returning to work.

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Attention: Disability Claims
PO BOX 800 STN C, KITCHENER ON N2G 4Y5
Tel: 1-877-481-9169 Fax: (519) 744-4519

1 Patient authorization

To be completed by patient.

Name of patient (last, first, middle initial)	Plan contract number	Employee certificate number
	84500	

Address (number, street, apartment)

City	Province	Postal code

Date of birth (dd/mmm/yyyy)	Height	Weight

"I hereby authorize the release to Manulife Financial 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 signed (dd/mmm/yyyy)**
✘	

2 Medical information

To be completed by patient.

List all doctors consulted for your present condition.

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)

Address of doctor (number, street, suite)	Date of next visit (dd/mmm/yyyy)

City	Province	Frequency of visits

Postal code	Telephone number	Type of practitioner
	( )	

Name of Doctor/Specialist	Approximately when did you first seek medical attention for this condition?	(dd/mmm/yyyy)

Address of doctor (number, street, suite)	Date of next visit (dd/mmm/yyyy)

City	Province	Frequency of visits

Postal code	Telephone number	Type of practitioner
	( )	

3 Attending Physician's Statement

Rest of form to be completed by physician

◯ Safety sensitive position ◯ Safety critical position

When did symptoms first appear or accident happen? Date (dd/mmm/yyyy)

What date did patient cease work because of illness/injury? Date (dd/mmm/yyyy)

Has patient ever had the same or a similar condition? ◯ Yes ◯ No

If "Yes", state when and describe.

A. History

Is condition due to injury or sickness arising out of patient's employment? ◯ Yes ◯ No ◯ Unknown

Is a claim being submitted to any type of worker's compensation board? ◯ Yes ◯ No

Has the patient been confined in a hospital? ◯ Yes ◯ No
If available please include admission and discharge summaries.

If "Yes"	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)
	Admission date (dd/mmm/yyyy)	Discharge date (dd/mmm/yyyy)

Name, specialty and address of other treating physician(s)

Name	Specialty	Address

B. Diagnosis

a) Primary

b) List any additional conditions or complications

c) Subjective symptoms

d) **Please include copies of the following documentation in support of the stated diagnosis: consultation notes, test/investigation report(s), psychological testing report(s), operative report(s), hospital admission and discharge summary(ies).**

If your patient is/was pregnant, please provide the expected/actual delivery date. (dd/mmm/yyyy)

4 Treatment

Frequency of visits		Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)
	Weekly		
	Monthly	Date of all visits between first and last visit (dd/mmm/yyyy)	
	Other (specify)		

Nature of treatment (including surgery, physiotherapy, psychotherapy)

Medications	Dosage	Side effects	Duration

4 Treatment *(continued)*

When do you expect a significant change in the functional limitation affecting your patient?

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

Is there potential for future improvement? ◯ Yes ◯ No

If no, please comment.

Have you recommended that your patient's driver's licence be revoked? ◯ Yes ◯ No

5 Physical impairment

Does your patient have a physical impairment?

◯ Yes ◯ No

If yes, please complete this section.

Based on objective findings please describe your patient's 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)		

Remarks

6 Cognitive/Mental impairment

Does your patient have a cognitive/mental limitation?

◯ Yes ◯ No

If yes, please complete this section.

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

	None	Mild	Moderate	Severe
◯ concentration (example attention, orientation)				
◯ analytical reasoning (example judgement)				
◯ learning new material (example memory)				
◯ comprehension				
◯ social interaction (example mood)				
◯ reaction time				
◯ ability to process information and react appropriately				

What is the DSM IV diagnosis? (Axis 1)

What is the current GAF?

Remarks

Please provide copies of consultation reports and your most recent mental status test results and list all abnormal findings supporting the above restrictions.

Competency

Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ◯ Yes ◯ No

7 Cardiac (if applicable)

Please include cardiac investigations.

a) Functional capacity (American Heart Association)

- ◯ Class 1 - Ordinary activity does not cause symptoms of undue fatigue, palpitations, dyspnea, or anginal pain.
- ◯ Class 2 - Greater than ordinary physical activity results in symptoms.
- ◯ Class 3 - Ordinary physical activity results in symptoms.
- ◯ Class 4 - Symptoms at rest, and worse with any physical activity.

b) Blood pressure (last 3 visits)

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

SYSTOLIC / DIASTOLIC

8 For Canadian Pacific Railway Occupational Health Services

(To be completed by attending physician)

Based on any restrictions listed above, is your patient fit to return to **modified duties**? ◯ Yes ◯ No — Date (dd/mmm/yyyy)

Based on any restrictions listed above, is your patient fit to return to **gradual duties**? ◯ Yes ◯ No — Date (dd/mmm/yyyy)

Based on any restrictions listed above, is your patient fit to return to **regular duties**? ◯ Yes ◯ No — Date (dd/mmm/yyyy)

Duration of restrictions — Date (dd/mmm/yyyy)

In your opinion, is your patient capable of performing duties that are critical to his/her own safety or to the safety of others? ◯ Yes ◯ No

If your patient is unfit for work at this time, when is the next reassessment date? (dd/mmm/yyyy)

Estimated Return to Work Date (dd/mmm/yyyy)

Prognosis for Return to Work

9 Comments

10 Physician's authorization

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife Financial 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.

Attending physician (please print)

Certified specialist	Telephone number (include area code) ( )
Address (number, street, city, province, postal code)	Fax number (include area code) ( )
Signature	Date signed (dd/mmm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM, IN THE PROVINCES WHERE APPLICABLE.