

Hospital and Home Care Plan Claim Retired Women Teachers of Ontario

This report is to be completed when you are making a claim for an illness or injury. You can help us to expedite the handling of your claim by making sure that all questions are answered and by attaching all original receipts or itemized statements for which you are claiming benefits.

**Return completed form to: Attention: Affinity Markets
Manulife Financial
PO BOX 4214 STN A
TORONTO ON M5W 5M4**

1 Claimant's statement

Name (last, first, initial)		Phone number ()
Address (number, street and apt. number)		
City	Province	Postal code
Date of birth (dd/mmm/yyyy)	Plan number 1777C	Identification number
My claim is the result of <input type="radio"/> Accident <input type="radio"/> Illness		
Date of accident/initial onset of illness (dd/mmm/yyyy)	Date of initial medical consultation (dd/mmm/yyyy)	
Full details of accident/illness		
Name and address of attending physician		
If hospitalized, provide name and address of hospital.		
Admission date (dd/mmm/yyyy)	Date of discharge (dd/mmm/yyyy)	
If outpatient surgery was performed, please provide name of hospital, date and type of surgery.		
After discharge from hospital, on what date did you resume your normal daily outdoor activities (ie. shopping, visiting, etc)?	Date (dd/mmm/yyyy)	
If you are still confined to your home, when do you expect to resume your daily outdoor activities?	Date (dd/mmm/yyyy)	
Have you ever had this or a similar condition in the past? <input type="radio"/> Yes <input type="radio"/> No		
If yes, please confirm date and name of treating physician.		
Indicate which of the following benefits you are claiming.		
<input type="radio"/> Convalescence indemnity (following hospitalization)	From (dd/mmm/yyyy)	To (dd/mmm/yyyy)
<input type="radio"/> Convalescence indemnity (following outpatient surgery)	From (dd/mmm/yyyy)	To (dd/mmm/yyyy)
<input type="radio"/> Fracture indemnity (specify which bones)		
<input type="radio"/> Home nursing benefit (receipts required)		

Please attach original receipts or itemized accounts.

Please complete next page.

- Transportation benefit (to and from hospital or doctor's office; receipts or itemized statement required)
- Comfort care benefits (during hospitalization; no receipts required)
- Ambulance/taxi benefit/private ambulance (receipts required)
- Assistive devices benefit (receipts required)
- Physician validation expense (receipts required)
- Physiotherapy benefit (receipts required)
- Special equipment benefit (receipts required)
- Cataract surgery benefit (receipts required)
- Other (please specify):

Please sign here

Claimant signature	Date signed (dd/mmm/yyyy)
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2 Medical authorization

I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, any type of workers' compensation board and investigative agencies, to release and exchange such information requested by Manulife Financial and/or its claims service providers for the purpose of plan administration including processing and investigating this claim. I authorize Manulife Financial and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any information needed for the purpose of plan administration including processing and investigating this claim. I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Please sign here

Claimant signature	Date signed (dd/mmm/yyyy)
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PLEASE BE SURE TO HAVE YOUR DOCTOR COMPLETE THE NEXT SECTION OF THIS FORM.

3 Attending physician's statement

This portion is to be completed by the physician.

Patient's name (last, first, initial)		
Diagnosis including complications (If fracture, specify bone and show whether complete or not.)		
Date of first consultation regarding this condition (dd/mmm/yyyy)	Remained under medical care (dd/mmm/yyyy)	
Name of referring physician		
Was patient ever previously treated for this or similar situation? <input type="radio"/> Yes <input type="radio"/> No		
If yes, state when (dd/mmm/yyyy)		
If condition caused hospitalization, please provide dates.		
Admission date (dd/mmm/yyyy)	Date of discharge (dd/mmm/yyyy)	
If condition required surgery as an outpatient of a hospital, please specify type of surgery.		
How soon after discharge from hospital would patient have been able to get outdoors unassisted for purposes such as shopping, visiting, etc?		Date (dd/mmm/yyyy)
Signature of physician		Date signed (dd/mmm/yyyy)
Address (number, street and suite number)		
City	Province	Postal code
Telephone number ()	Fax number ()	