



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

- **Plan Member Statement**
- **Plan Sponsor Statement**
- **Attending Physician's Statement**

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

Please see page 2 for instructions.

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) **This form must be completed and submitted within 30 days of the onset of disability.**
- 4) The WIB form has **three parts**:
 - a) **Employee Statement** – complete this portion **immediately** and mail or fax it directly to your Time Administrator (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 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.
- 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.**



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

Group Benefits Member 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: 1-877-481-9196 Fax: (519) 744-4519

1 Plan member information

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

Plan contract number 84500	Plan member certificate number	Union	
Plan sponsor's name Canadian Pacific Railway	Job title	<input type="radio"/> Safety sensitive	<input type="radio"/> Safety critical
Plan member's full name (last, first, initial)		<input type="radio"/> Mr.	<input type="radio"/> Ms.
		<input type="radio"/> Miss	<input type="radio"/> Mrs.
Birthdate (dd/mmm/yyyy)	Preferred language: <input type="radio"/> English <input type="radio"/> French	Height	Weight
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?	<input type="radio"/> Yes	<input type="radio"/> No	<i>If no, please go to section 3, Work information.</i>
What kind of accident?	<input type="radio"/> Motor vehicle accident <input type="radio"/> Work related <input type="radio"/> 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 <input type="radio"/> a.m. <input type="radio"/> p.m.	
Is there any legal action involved?	<input type="radio"/> Yes	<input type="radio"/> No	<i>If yes, please provide the following information:</i>
Lawyer's name	Telephone number ()		
Was the occurrence investigated by police?	<input type="radio"/> Yes	<input type="radio"/> No	<i>If yes, please provide a copy of the police report.</i>

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)		FREQUENCY				AMOUNT
		START	END	WEEKLY	BI-WEEKLY	MONTHLY	LUMP SUM	
Any type of workers' compensation board*				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Motor Vehicle Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Employment Insurance				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
Other				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$

* 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 Plan Sponsor. **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.

Plan member's signature

X

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.

Plan member's signature

X

Date signed (dd/mmm/yyyy)

Group Benefits

Plan Sponsor Statement

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

- To be completed by the plan sponsor.
- Please print clearly and answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- Provide the plan member with a Member Statement form and an Attending Physician's Statement form for the family physician or attending specialist. Ask the plan member to complete the "Patient authorization" section 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: 1-877-481-9196 Fax: (519) 744-4519

1 Plan sponsor	Plan contract number 84500	Division number (Union)	Company name Canadian Pacific Railway
	Address (number, street, suite)		
	City	Province	Postal code
	Contact name	Title	Telephone number () Fax number ()
2 Plan member identification	Name (last, first, initial)		<input type="radio"/> Male <input type="radio"/> Female
	Plan member certificate number	Date of birth (dd/mmm/yyyy)	
3 Plan member information	Date of hire (dd/mmm/yyyy)	Date eligible for benefit (dd/mmm/yyyy)	Department
	Plan member's job title	<input type="radio"/> Safety sensitive <input type="radio"/> Safety critical	Union affiliation of plan member
	Name of plan member's supervisor/manager		Telephone number of supervisor/manager ()
	Date last worked (dd/mmm/yyyy)		
	Reason plan member stopped working <input type="radio"/> Illness <input type="radio"/> Injury <input type="radio"/> On layoff <input type="radio"/> Leave of absence <input type="radio"/> Dismissed <input type="radio"/> Resigned <input type="radio"/> Strike <input type="radio"/> Other _____		
	Has the plan member returned to work? <input type="radio"/> Yes <input type="radio"/> No		
	If yes, please provide (dd/mmm/yyyy) date returned to work.		If no, please provide (dd/mmm/yyyy) expected return date.
	Has coverage terminated? <input type="radio"/> Yes <input type="radio"/> No If yes, please state when and reason why.		
	Date coverage terminated (dd/mmm/yyyy)	Reason for termination of coverage	
4 Plan member's earnings and benefit information	<i>Please provide the following information, OR a copy of the current payslip.</i>		
	Weekly salary/wage when member was last at work \$		
	Other income (if applicable) \$	(Overtime, bonus, shift differential as per policy provisions)	Date of last salary change (dd/mmm/yyyy)
It is important all sources of income be reported immediately. It is possible that these may impact potential benefit payment.	Is employee on spare board, relief, or casual employment? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Other _____		
	<i>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.)</i>		

5 Tax information

Please complete as benefit is taxable.

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

TD1	TP1	Member's province of residence for income tax purposes
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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Severance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
General holiday	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Retirement or pension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			\$

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 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 information contained herein.

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: 1-877-481-9196 Fax: (519) 744-4519

1 Patient authorization

To be completed by patient.

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

A. History

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.

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

TCRC Moose Jaw

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	Weekly	Date of first visit (dd/mmm/yyyy)	Date of last visit (dd/mmm/yyyy)
	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
<input type="radio"/> concentration (example attention, orientation)				
<input type="radio"/> analytical reasoning (example judgement)				
<input type="radio"/> learning new material (example memory)				
<input type="radio"/> comprehension				
<input type="radio"/> social interaction (example mood)				
<input type="radio"/> reaction time				
<input type="radio"/> 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)

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SYSTOLIC DIASTOLIC
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