Manulife

Claimant's Statement for Childbirth Benefits

Where to send your information

Email: Affinity_DI_Claims@manulife.ca

Fax: 1-800-363-5123

Mail: Manulife – Affinity Markets
P.O. Box 4213
STN A
Toronto ON M5W 5M3

1 Personal information

Name (first, middle initial, last)

Member Name

Member date of birth (dd/mmm/yyyy)

Home address

City

Province

Postal Code | Primary Phone Number

2 Childbirth information

Date of delivery (dd/mmm/yyyy)

Type of delivery: SVD ◯ C-Section ◯

3 Authorization to release information

In this section ***we, us*** and ***our*** refer to The Manufacturers Life Insurance Company; ***you*** and ***your*** refer to the insured person.
You authorize and direct any doctor, medical practitioner, health care professional, hospital, clinic and other medical or medically related facility, insurance company or their service providers, the Medical Information Bureau, other organization, institution, association or person that has any information, records or knowledge of you, to release to and exchange with us and applicable reinsurers any information about you that we require to administer this claim.
By signing below, you are confirming that:

- to the best of your knowledge, all of the information in this Claimant's Statement is current, correct and complete
- you agree to the terms of this Claimant's Statement
- you make all authorizations and give your consent as described in this Claimant's Statement
- you agree to refund any monies which may be due to Manulife as a result of an overpayment of benefits
- you agree that a copy of this authorization shall be as valid as the original
- you have reviewed your insurance certificate(s) and confirm that the answers to the questions on the application were accurate, complete, and true at the time the answers were provided and the certificate(s) was received.

Provincial legislation in some provinces requires us to inform you that the time limit for taking legal action is set out in the Insurance Act or other legislation that applies to your claim.

Fraud Notice: Any person who knowingly files a claim containing any false or misleading information is subject to criminal and civil penalties. In addition, the insurer may deny insurance benefits if false information materially related to a claim or an application for insurance was provided by the applicant.

Please print.

Name of insured person

Sign here.

Signature of insured person | Date (dd/mmm/yyyy)

Questions? Call us at 1-888-272-4492