

Manulife Financial
Integrated Absence Solutions
P.O. Box 4606 Stn. A
Toronto, ON M5C 3G7

Employee Full Name (Last, First, Middle Initial): _____

Employee No: _____

Date of Birth: _____

To Whom it May Concern:

I will not be signing the Manulife Financial Authorization Form because I believe that it violates my right to medical privacy. I will not sign such an open-ended authorization for Manulife, or for anyone, to obtain my personal medical information. As a Disability Management Agent, Manulife Financial is entitled only to information regarding my ability or inability to perform my regular or modified work duties, any medical restrictions which may be required for me to return to such work duties, as well as the expected duration of such restrictions.

I am willing to cooperate by providing you with the medical information pertaining to my immediate condition. Please provide me with a form requesting such specific information. I will then get the form completed and will return it to Manulife.

If Manulife has specific additional questions for my medical practitioner, I will discuss the questions with my medical practitioner and will authorize my medical practitioner to answer those questions, if questions are not in violation of my right to medical privacy.

Dated this _____ day of _____, 2007.

Employee signature