Disability Job Demands Questionnaire
SunAdvantage

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

This form is to be completed by the Plan Sponsor and submitted with the Plan Sponsor's Statement if the plan member is expected to be absent for 4 weeks or more.

1 Plan member information

Contract number	Sub./Class	Member ID	Division/Billing group number

Last name (Quebec residents – maiden name)	First name

☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Company name
	_ _	

Regular occupation title/Job name

2 Work environment and job activities

The remainder of this form asks for information on the plan member's specific job duties and should be completed by the plan member's immediate supervisor.

Attach extra sheets, if necessary.

If there is a prepared job description, please attach it to this form.

1. Does the plan member's job require work in any of the following conditions:

Outside	☐ No	☐ Yes	If yes, what percentage of time?	%
In extremes of cold or heat	☐ No	☐ Yes	If yes, what percentage of time?	%
In a damp or humid environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a noisy environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a dusty or unventilated environment	☐ No	☐ Yes	If yes, what percentage of time?	%
Around toxic fumes	☐ No	☐ Yes	If yes, what percentage of time?	%

2. Does the plan member's job involve handling chemicals? ☐ No ☐ Yes
If yes, please list the chemicals below.

3. During the plan member's normal routine, what percentage of time does the job require the member to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
More than 50 lbs/22.7 kg	☐	☐	☐	☐	☐
More than 20 lbs/9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs/4.5 kg	☐	☐	☐	☐	☐

2 Work environment and job activities (continued)

4. During the plan member's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

5. How much time is the plan member required to maintain the following activities before changing position or activity?

	0 to 30 minutes	30 to 60 minutes	60 to 90 minutes	More than 90 minutes
Sitting at one time	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐

6. During the average day, what is the number of hours the plan member spends in the following positions or activities?

	0 to 2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Driving	☐	☐	☐	☐

7. Please list any machines, tools, or other equipment that the plan member uses on the job. You can either list the number of times per day the equipment is used or the percentage of time spent using the equipment, whichever is more applicable.

Type of equipment	No. of times per day OR Percentage of time

8. Cognitive/non-physical aspects of the job

Does the plan member have to answer complaints? ☐ Yes ☐ No

Is the plan member primarily evaluated on production? ☐ Yes ☐ No

Does the plan member work closely with co-workers? ☐ Yes ☐ No

Is the plan member responsible for the performance objectives/decision–making within his/her particular department? ☐ Yes ☐ No

Number of people this plan member supervises: ☐

What percentage of the plan member's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

Please list any other relevant aspects of the job that may be considered stressful.

3 Additional remarks

Please provide any additional information that may be relevant to this claim which has not been previously provided.

4 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First Name
Position of person signing this statement (please print)	
Authorized signature X	Date (dd-mm-yyyy) – –
Telephone number – –	Fax number – –

Visit our website:
www.sunlife.ca/
health and work

To ensure prompt submission, please fax this form, along with any other information in support of the plan member's claim, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

If you live in the Atlantic provinces, Quebec or Ottawa

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

For all other provinces or territories

Kitchener – Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9