Plan member's update
Long-Term Disability benefits
(Formerly, Continuation of Ongoing Total Disability form)

Sun Life Financial

This form is required to update us regarding your employment status, medical condition and any other sources of income. Please ensure that this information is sent to us in a timely manner to avoid any interruption in your benefits. It is your responsibility to inform our office immediately of any changes, so that we can review your claim for any adjustments.

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

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1 Plan member information

Please complete this section in full, even if your information has not changed, in order to ensure that our records are current.

Control number	Contract number	Member ID	Date of birth (dd-mm-yyyy)

Last name (Quebec residents – maiden name)	First name

Home telephone number	Alternate telephone number	Email address

Address (street number and name)	Apartment or suite	City	Province	Postal code

2 Your current work and/or retraining information

Please check all that apply. Are you currently: Working? ☐ No ☐ Yes Retraining? ☐ No ☐ Yes Volunteering? ☐ No ☐ Yes

Please provide details.

3 About your illness/injury

Has your current medical condition improved? ☐ No ☐ Yes

Last name of your doctor	First name

Telephone number	Have you been seen by your doctor/specialist in the last year? ☐ No ☐ Yes If yes, how many times? _____

4 Retirement pension information

Please note retirement pension may include a lump sum amount approved by your employer or retirement plan that is deferred/locked in.

Have you contacted your employer to consider any pensions that may be available to you at this time? ☐ No ☐ Yes	
Have you applied for a retirement pension? ☐ No ☐ Yes	
If yes, has your application been approved for: ☐ Medical Retirement Pension ☐ Normal Retirement Pension ☐ Other (i.e., a deferred payment) _____	Effective date (dd-mm-yyyy)
If your application has been approved, please provide the amount of your pension $ ☐ monthly ☐ lump sum	
Has your application been declined? ☐ No ☐ Yes	Date (dd-mm-yyyy)

5 Confirmation of all other income you are currently receiving

Your Group Long Term Disability policy indicates that your disability benefits may be reduced by payments received from other sources for the same or subsequent disability such as Canada Pension Plan/Quebec Pension Plan, Workers' Compensation, work for remuneration or Pension plan payments.

Please confirm if you are currently receiving any other income:

Workers' Compensation/Workplace Safety and Insurance Board benefits ☐ No ☐ Yes

WCB/WSIB/CSST Claim Number	Monthly amount $	Effective (dd-mm-yyyy)

Canada/Quebec Pension Plan (CPP/QPP) benefits ☐ No ☐ Yes

☐ Disability ☐ Retirement	Monthly amount $	Effective (dd-mm-yyyy)
	Dependent amount $	Effective (dd-mm-yyyy)

Any other income (e.g., from other insurance companies, legal action, etc.) ☐ No ☐ Yes

Please specify sources, amounts and effective dates.

6 Contact authorization

If attempts to contact you are unsuccessful, do you authorize us to contact anyone else? If so, please indicate below.

Last name	First name	Relationship to the Plan member	
Address (street number and name)		Apartment or suite	
City	Province	Postal code	Home telephone number

7 Declaration of Plan member (or Power of Attorney for Property)

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

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my claim. I authorize Sun Life and its reinsurers to collect, use and disclose information needed for underwriting, administration, adjudicating claims under this Plan to any person or organization who has relevant information pertaining to my claim including health professionals, institutions, investigative agencies, insurers and, where applicable, my Plan Sponsor. I agree that Sun Life and my Plan Sponsor may also share financial information related to my claim for purposes relevant to the management of this Plan. I understand that information about me pertaining to my claim may be reviewed in the event this Plan is audited.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

Signature of Plan member/Power of Attorney	Current date (dd-mm-yyyy)
X	

If you are the Power of Attorney for Property and you have completed and signed this form on behalf of the Plan member, please complete the following section.

Last name	First name	Relationship to the Plan member	
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Home telephone number	Alternate telephone number	Email address	

Do you have Power of Attorney for this member?
☐ No ☐ Yes If yes, have you provided supporting documentation? ☐ No ☐ Yes If no, please provide it with this form.

If you do not have Power of Attorney, please state the reason you are completing this form.

Please fax or mail to the Sun Life Assurance Company of Canada Group Disability Management office that is managing your claim. Please retain the original copy for your records. You do not need to mail information that you fax to us.

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

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

Montreal – Contract number 12500
Fax: 1-866-639-7849
1155 Metcalfe St
PO Box 12500 Stn CV
Montreal QC H3C 5T6

8 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.