

Short-Term Disability Claim Guide

Short-Term Disability (STD) coverage provides benefits to you when you are disabled. This guide is designed to help you through the claim submission process and to answer any initial questions you may have with respect to filing a claim for Short-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.



When we receive your claim.

Your Case Manager reviews all the information received about your claim and the contract provisions. As part of this review, they look at:

- the medical information
- the impact your condition has on your ability to function and carry on your daily activities
- your occupational duties
- how your condition affects your ability to perform your occupation

As part of this review, your case manager may contact you by phone to discuss your claim. They may have some questions for you to better understand your condition, but this is also an opportunity for you to ask them any questions you may have about your claim. They may also need to contact your doctor and/or employer to ask some further questions or to obtain any missing information.



We'll let you know.

The claims assessment process usually takes 5 business days after we receive all the necessary information. If your claim is approved based on your employer's STD plan, your case manager will notify you and your employer in writing. If your claim is not approved, your case manager will notify you in writing and provide the reasons for the decision.

For some claims, we may determine that we don't have enough information to make an informed decision.



Your information is confidential.

We treat the information you provide to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's Statement, or as permitted or required by law.

Reporting your absence

To apply for STD benefits, you and your employer will need to send us a completed STD form package.

The package contains three forms:



A Plan Sponsor's Statement, which your employer completes and sends to us separately;



A Plan Member's Statement, which you must complete and return to our office.



An Initial Disability Insurance Medical Statement, which you take to your doctor to complete.

Note: Your doctor may charge you a fee to complete this form. If so, you will be responsible for paying that fee.



Complete the Plan Member's Statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence.
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Provide the required document outlined in the "Automatic deposit of your disability payments" section if you would like to have your payments deposited into your bank account. For chequing accounts, we will require a personalized VOID cheque.
- Read and sign the Authorization which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. Also, please sign Part 1 of the Initial Disability Insurance Medical Statement before giving the form to your physician to complete.



Have your physician complete the Initial Disability Insurance Medical Statement

This statement provides us with specific medical information about your condition and your expected recovery.

- The Initial Disability Insurance Medical Statement must include all the information requested about your condition. This form can be completed by your family doctor, a doctor at a walk-in clinic, a specialist or nurse practitioner - any medical professional who is a doctor of medicine and that has treated you for your condition.
- If your doctor has conducted tests, a copy of the findings must be included with the Statement.
- If you have seen a specialist for your condition, be sure to have your doctor send us copies of all consultation and clinical notes with the Statement.

Note: Do not change or write anything on the Initial Disability Insurance Medical Statement. Any changes to the Statement must be initialed by your doctor.



Sending in your forms

- Follow up with your doctor (if the form was left with them for completion) and employer to confirm they have completed, signed and submitted their forms to our office.
- We recommend you submit the completed claim forms as soon as possible after the beginning of your absence, as most contracts limit the period of time in which to submit a claim.
- Send in your forms using one of the options provided on the last page of the Plan Member Statement.



Be sure your group Contract number and your Member ID number are clearly shown on your Plan Member's Statement and Initial Disability Insurance Medical Statement before submitting the forms to us.

If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.



FAQs

We want you to feel comfortable with the Short-Term Disability claims process. This Frequently Asked Questions guide is designed to help you understand more about the process, from claims submission through to your recovery.

What does plan sponsor mean? The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your plan.

What are my Contract and Member ID numbers? The Contract number refers to the document that outlines your plan sponsor/employers benefits plan with Sun Life Financial. The Member ID is the number used to identify you specifically. These numbers can be found on your coverage or enrollment summary or in your employee benefits booklet.

Why does my doctor need to fill out the Initial Disability Insurance Medical Statement? The Initial Disability Insurance Medical Statement has been designed to ask your doctor for information that will help us understand the nature of your condition and how it impacts your functional abilities. If your doctor provides only part of the information requested, or a brief note on a doctor's prescription pad, we may not have all the information needed to assess your request for benefits. This will potentially delay a decision on your claim.

How are my benefits calculated? Disability benefit payments are usually based on a specific percentage of your weekly earnings at the time you become disabled. The benefit amount under your plan is specified in your employee benefits booklet.

If my claim is approved, when do my payments start? Your disability benefit payments will be paid from the day following the completion of the elimination period. The elimination period is outlined in your employee benefits booklet. If this date is in the past, then payment will be made back to this date, for the retroactive amount owing.

How and when are payments made once the claim is approved? If you would like to have your benefits deposited directly into your bank account, the Plan Member's Statement outlines what information is needed in order to set this up - see Automatic deposit of your disability payments. Don't forget to review this section and provide the required documentation. For chequing accounts, we will require a personalized VOID cheque. NOTE: There may be a delay in payment if a scheduled payment falls on a holiday.

How long will I receive disability payments? For STD, you will continue to receive disability benefit payments as long as you meet the definition of total disability. Usually, this means you are 'totally disabled' for your own occupation up to the maximum benefit period. The definition of total disability and the maximum benefit period for your plan are defined in your employee benefits booklet. There are also other requirements you must meet in order to continue to receive disability benefit payments. These include continuing to explore new employment opportunities, pursuing appropriate treatment or attempting modified work duties. Please consult your employee benefits booklet for the specific details of your plan.

What are my responsibilities while I receive disability benefits? While you are in receipt of disability benefits, we will talk to you about returning to work, at the appropriate time. We expect that you will participate in these discussions, and return to your own occupation as soon as it is safe and healthy for you to do so. If it becomes apparent that you will not be able to return to your own occupation, you will be expected to consider any reasonable offer of modified work with your employer.



Once I've been approved for benefits, how often is medical information requested? A clear understanding of the progress of your recovery is considered essential in preparing for a potential return to work. Periodic updates on your medical condition and functional status help us determine your progress. The frequency of status reports will be determined by the unique circumstances of your claim, your medical condition and treatment plan. We will follow up with you and your treating doctor(s) by telephone or mail. Your Case Manager will work with your doctor and Sun Life's Health Partners to ensure you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam to get more information. We will arrange the appointment and give you adequate advance notice. (We will provide a copy of the results to your treating doctor.)

When would benefits not be paid?

Benefits may not be paid if you:

- are not considered totally disabled
- are not receiving or following appropriate treatment as recommended by your treating doctor
- are not participating in a Sun Life-approved rehabilitation program
- are on leave of absence, strike or lay-off, except where Sun Life specifically agreed to the continuation of coverage or as required by law
- are absent from Canada due to any reason, unless you have received written agreement from our Case Manager in advance to pay benefits during this period
- complete any work for wage or profit except as approved by us
- serve a prison sentence or are confined in a similar institution

Please consult your employee benefits booklet for the specific details of your plan.

What if I receive income from another source? How will that impact my benefit? Your employer's STD plan may indicate that your disability benefit payments are reduced by payments received from other sources, such as Canada Pension Plan (CPP), Quebec Pension Plan (QPP) and Workers' Compensation for the same or subsequent disability. Your benefit payment will not be reduced by income you receive from an individual disability plan. A retroactive award from another source may reduce your disability benefit payments and may result in an overpayment. If this situation occurs, you are expected to reimburse the amount overpaid.

What if I return to work with some restrictions? Your Case Manager will work with you and your employer to develop a return-to-work plan that accommodates what you are able to do. Your return-to-work plan could include, for example, a gradual increase in hours and/or modified duties. Should your return to work require specific vocational expertise, we may involve one of our Health Management Consultants to assist with planning your return to the workplace. We will contact your doctor to ensure he or she is aware of the plan before it begins. Once you're back performing the essential duties of your occupation, full-time, Sun Life is usually no longer involved.

What happens if I'm unable to return to work before the maximum benefit period? If your absence is anticipated to extend beyond the maximum benefit period provided under your employer's STD plan, and you have LTD coverage with us we will rely on the medical information gathered during the management of your STD claim to make a decision on your entitlement to Long Term Disability benefits. Your Case Manager will provide you with further information at that time.

Will I receive a tax slip? A tax slip will be issued if the disability benefit payments you receive are taxable income. Tax slips are mailed by the end of February every year, for the previous tax year. If you are unsure if the disability benefits payments you receive are taxable income, please contact your Benefits Administrator.

*This guide is not intended to replace or amend your employee benefits booklet. If there are any discrepancies between your employee benefits booklet and the information in this guide, the group benefits booklet will take priority.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life group of companies. PDF8006 01-26 lj-cc



Plan Member's Statement Claim for Disability benefits



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

1 Plan Member information

In order to avoid any delays in the assessment of your Short-Term Disability (STD) and where applicable, Long-Term Disability (LTD) claim, we also require the Plan Sponsor's Statement and the Initial Disability Insurance Medical Statement to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If disability benefits under your Short-Term Disability or if applicable, Long-Term Disability Plan are taxable, your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Occupation	Job title	Social Insurance Number	
Home telephone number		Alternate telephone number	
What province were you living in at the time your coverage became effective under this plan?		Preferred language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French	

If you would like Sun Life to email you, please fill in your email address below. Sun Life will write to you through secure email.

Email address

2 Plan Sponsor information

Contract number	Member ID	Company name
Contact person	Contact person email	Contact person phone number

3 About your illness or injury

You must notify Sun Life if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

1. Please describe your present illness or injury and how it occurred.

Date (dd-mm-yyyy)

2. When did your symptoms first appear?

3 About your illness or injury

3. Have you ever had the same or similar illness or injury? No Yes If yes, please explain and give dates.

Date (dd-mm-yyyy)

4. Is your condition related to pregnancy? No Yes If yes, what is your delivery date?
Please describe your complications, if any.

Date (dd-mm-yyyy)

5. From what date did your illness or injury prevent you from working?

6. Please include a list of the duties of your job that you are unable to do.

7. What treatments are you presently receiving (Medications, physiotherapy, psychotherapy, etc.)

8. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

9. When do you expect to be able to return to work?

Date (dd-mm-yyyy)

- Full-time
 Part-time

10. Have you tried to return to work already? No Yes If yes, please answer the following questions.

Date (dd-mm-yyyy)

Date (dd-mm-yyyy)

What were the dates that you returned to work? From

Did you return to: your own job new job or modified duties

Did you return to: full-time part-time

4 Disability as a result of an accident

1. Is your disability the result of an accident?

- No If no, continue with the next section "Your other income".
 Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location
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2. Were you working for your employer at the time of the accident? No Yes Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident? No Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number

3. If your disability is the result of an accident, are you taking legal action against any other person or organization?

- No If no, explain why you are not taking legal action.

- Yes If yes, please complete the following:

Name of lawyer		Telephone number	
Address	City	Province	Postal code

Date (dd-mm-yyyy)

On what date did the legal action start?

Has a settlement been reached? No Yes If yes, please attach a copy of the terms of the settlement.

5 Your other income

Please list any amounts of money you are currently receiving or expect to receive each week or month from the following sources. We may take some of these amounts into consideration when we calculate your Short-Term Disability benefit.

Source	Insurance Co. & Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per <input type="checkbox"/> Week <input type="checkbox"/> Month	When are your benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. WCB/WSIB/ CNESST, Union Disability Benefit, Creditor, Credit Cards, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Auto Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other Group/Association/Individual Plans		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Employment Insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Quebec Parental Insurance Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Canada/Quebec Pension Plan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Employer Disability, Severance or Retirement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Any other Accident/Group/Association/ Government Disability Benefit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other (specify) i.e. in Quebec, Criminal Victims Benefits		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	

6 Automatic deposit of your disability payments

This service is subject to the approval of your claim.

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. **If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque.** Please check with your Benefit Administrator to determine if this option is available to you.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

7 Your permission

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

Reference to Sun Life, the plan sponsor or employer includes their agents, service providers and, where applicable, reinsurers.

The Purposes

I authorize Sun Life to collect, use and disclose relevant information about me for purposes that include:

- underwriting and plan administration;
- assessing and administering my claim for short-term disability (STD) or long-term disability (LTD) benefits;
- coordinating or verifying benefits or payments from other insurers, government agencies or third parties;
- assisting with rehabilitation, accommodation or return-to-work planning;
- detecting, preventing or investigating actual or suspected fraud or plan abuse;
- responding to or managing any appeals, complaints, reviews or overpayment recovery efforts; or
- defending, responding to or participating in any demand, legal proceeding, regulatory complaint or investigation, or dispute resolution process (such as arbitration or mediation) about my STD or LTD claim.

Sun Life can use and rely upon my coverage and claims information under any Sun Life benefits plan when such information is relevant to my STD or LTD claim for the purposes set out above.

The Sources of Information

I authorize Sun Life and the following individuals or entities to collect, use and disclose information:

- physicians, specialists, psychologists and all other health care professionals or providers;
- hospitals, clinics, facilities, and rehabilitation centres;
- my plan sponsor, employer, and unions (excluding information about my diagnosis and treatment);
- occupational health services team of my plan sponsor or employer (including information about my diagnosis and treatment);
- regulators, government bodies, law enforcement, investigators and collection agencies;
- other insurers, CPP, QPP, workers' compensation boards, Employment Insurance, and the CRA; and
- any other person or organization having relevant information about me.

This authorization applies to all information relevant to my claim, including medical, functional, employment, financial and vocational records.

Overpayment

If Sun Life overpays me, I authorize Sun Life to recover overpayments from any benefits payable under this plan.

Duration of consent

My consent stays in effect until:

- my claim closes and all levels of appeal are exhausted;
- any disputes including regulatory complaints or investigations, arbitration, mediation or legal proceedings are resolved or complete;
- any remediation relating to overpayments, suspected or actual fraud, plan abuse or any investigations are resolved or complete.

I understand that I may revoke this consent at any time. If I revoke my consent, or even part of my consent, this will affect Sun Life's ability to assess, pay or continue my claim.

Information about my claim may be subject to a plan audit and may also be used to continue to improve disability and operational processes and systems, as well as plan member experience. This continues until Sun Life deletes my information under its record retention policy.

My typed name or a digital image of my signature is as valid as a handwritten signature. I can deliver this signed form electronically to Sun Life, including by email. Any copy of this signed form (scanned, photocopied, photographed, PDF or JPEG) shall be considered as valid as the original for all purposes.

Member's last name (please print)	First name
Member's signature X	Date (dd-mm-yyyy)

Instructions on how to submit your completed form(s) can be found on the next page.

8 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.



If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.



You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to disabilityclaims@sunlife.com. Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.



You can fax your completed claim forms to the number that appears below for the Sun Life Group Disability Management Office that manages your claims. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:

Fax: 1-866-639-7850

PO Box 11480 Stn CV

Montreal QC H3C 5P5

Kitchener - Waterloo:

Fax: 1-866-209-7215

PO Box 100 Stn C

Kitchener ON N2G 3W9

Montreal:

Fax: 1-866-639-7846

PO Box 11037 Stn CV

Montreal QC H3C 4W8

Edmonton:

Fax: 1-866-639-7820

PO Box 2733 Stn Main

Edmonton AB T5J 5C9

Toronto:

Fax: 1-866-639-7851

PO Box 950 Stn A

Toronto ON M5W 1G5

Vancouver:

Fax: 1-866-639-7829

PO Box 48810 Stn Bentall

Vancouver BC V7X 1A6

9 Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at www.sunlife.ca/privacy or call us for a copy.

Initial Disability Insurance Medical Statement

The patient is responsible for any fees related to the completion of this form.

Section 1	Patient Information and Consent TO BE COMPLETED BY THE PATIENT																				
Patient Name (Last, First, Middle Initial)		Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)																		
Address (Street, City, Province, Postal Code)																					
Employer's Name (if applicable)	Contract or Policy #	Certificate # (if applicable)	Date of Birth (dd-mm-yyyy)																		
Date Last Worked (dd-mm-yyyy)		Date Returned to Work or Expected Return to Work Date (dd-mm-yyyy)																			
Please list your present medications: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Name of Medication</th> <th style="width: 20%;">Dosage (mg)</th> <th style="width: 20%;">How Often?</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td>_____</td><td>_____</td></tr> <tr><td>2. _____</td><td>_____</td><td>_____</td></tr> <tr><td>3. _____</td><td>_____</td><td>_____</td></tr> <tr><td>4. _____</td><td>_____</td><td>_____</td></tr> <tr><td>5. _____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Name of Medication	Dosage (mg)	How Often?	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____	Please provide your: Height: _____ Weight: _____ Dominant Hand: Left <input type="checkbox"/> Right <input type="checkbox"/>
Name of Medication	Dosage (mg)	How Often?																			
1. _____	_____	_____																			
2. _____	_____	_____																			
3. _____	_____	_____																			
4. _____	_____	_____																			
5. _____	_____	_____																			
I hereby authorize the release of medical and health information in my file to _____ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan/insurance policy. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form. Medical and health information excludes genetic test results.																					
Patient Signature _____		Date of Consent (dd/mm/yyyy) _____																			
Section 2	Medical Statement TO BE COMPLETED BY THE DOCTOR (or applicable medical provider)																				
I am the: Family Physician <input type="checkbox"/> Consulting Specialist <input type="checkbox"/> Other <input type="checkbox"/> (please specify) _____																					
PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE																					
Diagnosis																					
Primary: _____																					
Secondary and/or Complications: _____																					
If Childbirth - Expected or Actual Delivery Date (dd-mm-yyyy): _____ Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/>																					

Is this condition due to:

Occupational Illness Yes No

Occupational Injury Yes No

Motor vehicle accident Yes No

Other accident Yes No

If yes, date of event: (dd-mm-yyyy) _____

Have you completed any other disability claim forms recently for this patient? Yes No

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

Date of first visit to you pertaining to this condition (dd-mm-yyyy)	First date of work absence due to condition (dd-mm-yyyy)
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Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

Frequency of Visits: Weekly Monthly Other (describe) _____

Date of last visit: (dd-mm-yyyy) _____

Date of next visit: (dd-mm-yyyy) _____

Has the patient been treated for this same or similar condition in the past? Yes No Unknown

If yes, date: (dd-mm-yyyy) _____ Treatment Provider: _____

Is the patient following the recommended treatment program? Yes No



Please elaborate: _____

Response to Treatment

Please describe the response to treatment to date: Complete Partial None Too soon to tell

Are there any plans to change or augment the current treatment program? Yes No

If so, please explain: _____

Hospitalization		
Is/was the patient hospitalized?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is future hospitalization planned? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did/will the patient have day surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please provide the following information or attach a copy of the admission, discharge, and/or operative report(s):		
Date of admittance (dd-mm-yyyy)	Date of discharge (dd-mm-yyyy)	Institution Name
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
If surgery was/will be performed, please provide date(s) and description of surgery(s):		
Date (dd-mm-yyyy)	Description	
1. _____	_____	
2. _____	_____	
	<ul style="list-style-type: none"> If your patient has returned to work, or if the duration of their disability will be less than 4 weeks, please stop here and sign the end of the form. For disabilities expected to be greater than 4 weeks, please complete all pages. 	
Investigations		
Please attach copies of all relevant:		
	<ul style="list-style-type: none"> test results/investigations (If test results are not attached, we will interpret this as tests were not performed) – <u>do not provide genetic test results</u> consultation reports clinical notes 	
Are tests/investigations pending? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date (dd-mm-yyyy)	Description	
1. _____	_____	
2. _____	_____	
If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Specialist	Specialty	Date (dd-mm-yyyy)
1. _____	_____	_____
2. _____	_____	_____

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency: _____

How have the patient's symptoms evolved to date? Improved No Change Retrogressed

Restrictions and Limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations: _____

Has any license held by the patient been restricted or revoked as a result of this condition? Yes No

If yes, as of when? (dd-mm-yyyy) _____ Type of license: _____

Is the patient capable of managing their own affairs? Yes No

Are there other contributing factors that you are aware of that may impact the patient's expected recovery period and return-to-work goals?

Yes No

Workplace Issues Social/Family Issues Financial/Legal Issues Personality issues Addiction Other

Please elaborate: _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

Notice to Physician/Medical Provider:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Name of Attending Physician/Medical Provider (please print)		Specialty and license/registration number	Date Signed (dd-mm-yyyy)
Address (Street, City, Province, Postal Code)		Telephone # (+ area Code)	Fax Phone # (+ area Code)
			Email address
Signature			

Return address

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. It can also be emailed to disabilityclaims@sunlife.com. If you choose to send your information by email, we can't guarantee the privacy or security of the email communications while they are on their way to Sun Life. Please retain the original copy for your records.

- | | | | |
|--|--|---|---|
| <p>Halifax:
 Fax: 1-866-639-7850
 PO Box 11480 Stn CV
 Montreal QC H3C 5P5</p> | <p>Montreal:
 Fax: 1-866-639-7846
 PO Box 11037 Stn CV
 Montreal QC H3C 4W8</p> | <p>Toronto:
 Fax: 1-866-639-7851
 PO Box 950 Stn A
 Toronto ON M5W 1G5</p> | <p>Kitchener - Waterloo:
 Fax: 1-866-209-7215
 PO Box 100 Stn C
 Kitchener ON N2G 3W9</p> |
| <p>Edmonton:
 Fax: 1-866-639-7820
 PO Box 2733 Stn Main
 Edmonton AB T5J 5C9</p> | <p>Vancouver:
 Fax: 1-866-639-7829
 PO Box 48810 Stn Bentall
 Vancouver BC V7X 1A6</p> | <p>Montreal
 Federal Government
 Disability Insurance Plan
 Fax: 1-866-639-7849
 PO Box 12500 Stn CV
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