

Your guide to reporting your absence

This guide will help you understand what we need to assess your absence so you can focus on your health.



Your plan sponsor has asked us to help you through the process of reporting your absence. Follow these steps and, if you have questions, we're here to help.

1.

Fill out and sign the Plan Member Statement. This statement gives us information about your condition, your treatment and your relevant medical history. Return the statement to us using the instructions on the form.

2.

Fill out and sign part 1 of the Attending Physician's Statement. This section of the form confirms your personal information. Signing it allows your doctor or nurse practitioner to exchange information with us.

3.

Ask your doctor or nurse practitioner to fill out the rest of the Attending Physician's Statement. This statement gives us information about your health condition and treatment plan. If your doctor or nurse practitioner charge a fee to fill out forms, you'll need to pay this cost.



What happens next?

- Your employer will fill out a **Plan Sponsor Statement form** and send it to us.
- Once we receive your employer's **Plan Sponsor Statement**, your **Plan Member Statement**, and the **Attending Physician's Statement**, we'll start our assessment.
- We'll connect with you about next steps. After we receive all three forms, you can expect to hear from us within 5 business days.



Don't forget!

For the Plan Member Statement:

- ✓ Be sure to answer all the questions in full so we have everything we need to assess your absence. This will help avoid delays.
- ✓ Double check all the dates you provide (for example, the date you were first unable to work, or the date of your accident). These are essential to our assessment.
- ✓ Check with your employer about any deadlines you have for sending us this form.
- ✓ Include your group contract number and your member ID number. If you're unsure about what these numbers are, contact your benefits administrator.

For the Attending Physician's Statement:

- ✓ Sign and date part 1 of the form.
- ✓ Include your group contract number and your member ID number. If you're unsure about what these numbers are, contact your benefits administrator.



Who does what?



Depending on the service your plan sponsor has chosen, we'll provide assessment, case management, or referral services.



For assessment and case management services, we review the medical reasons for your absence. We then make a recommendation to your plan sponsor about whether the medical information supports your absence.



Your **plan sponsor** provides the salary continuance program. They're responsible for deciding whether to continue paying your salary while you're off work.

Terms we use in this guide

Benefits administrator. This is the person who handles human resources questions where you work. Depending on the size of your company, it could be a team of people or a single person.

Plan sponsor. This is typically your employer, but can be a union or other organization that offers a group health plan to its employees or members.

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. PDF5337 05-23 ri-cd



Plan Member's Statement Salary Continuance Services



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 absence, 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 absence will be your responsibility.**

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		
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. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

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 Assurance Company of Canada 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 (continued)

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.

3 About your illness or injury (continued)

9. When do you expect to be able to return to work? Full-time
 Part-time
10. Have you tried to return to work already? No Yes If yes, please answer the following questions.

What were the dates that you returned to work? From to

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 declaration and authorization".
 Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location

2. Were you working for your employer at the time of the accident? Yes No 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

5 Your declaration and authorization

You must also sign and complete the Member's Authorization on the Initial Disability Insurance Medical Statement.

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 absence(s) from work. I authorize Sun Life to collect, use and disclose information needed for administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan ("this Plan") to any person or organization who has relevant information pertaining to my absence(s) from work 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 absence(s) from work for purposes relevant to the management of this Plan. I understand that information about me pertaining to my absence(s) from work may be reviewed in the event that this Plan is audited.

I authorize Sun Life to collect from and discuss with my Plan Sponsor any information in my Plan Sponsor's file (including diagnosis, treatment or medication) pertaining to my absence(s) and to use such information for the purposes described in the paragraph above.

I also authorize Sun Life and my Plan Sponsor to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **except** for details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I also authorize Sun Life and my Plan Sponsor's medical consultants to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purpose of facilitating in the resolution of any litigation or any other formal legal proceeding (threatened or actual) relating to my absence(s) from work that I may raise or commence against my Plan Sponsor.

I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Any reference to Sun Life or my Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

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

Please notify Sun Life Assurance Company of Canada and your Plan Sponsor of your expected return to work date. Instructions on how to submit your completed form(s) can be found on the next page

6 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 Assurance Company of Canada 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

7 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) – do not provide genetic test results 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
 Montreal QC H3C 5T6</p> | |