

Plan Sponsor's Statement Claim for Short-Term Disability benefits



Sun Life commits to keeping plan members' personal information confidential.

The information on the Plan Sponsor's Statement is for the assessment of the plan member's absence from work. This statement forms part of the plan member's disability claims file. We will release this statement to the plan member if they request their file.

1 Plan Member information

Sun Life must receive the Plan Member's Statement, Initial Disability Insurance Medical Statement and this form in order to review this claim. Please complete this form in its entirety in order to avoid delays.

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
Home telephone number		Alternate telephone number	
Regular occupation title/Job name			

2 Plan Sponsor information

Please also submit the form, Disability Job Demands Questionnaire if the member is expected to be absent for 4 weeks or more.

Contract number	Sub./Class	Member ID	Division/Billing group number
Company name			
Address (street number and name)			
City			Province Postal code
Contact person			
Contact's telephone number	Ext.	Email address	

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Dates that pertain to the absence from work due to the current disability.

Date member started with the company (dd-mm-yyyy)	Last date of full-time duties/hours (dd-mm-yyyy)	Last date of modified work (if applicable) (dd-mm-yyyy)
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Date (dd-mm-yyyy)

Was the member's employment terminated? No Yes If yes, on what date?

To the best of your knowledge, why did the member stop working?

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3 Employment information (continued)

Date member returned to full-time duties (dd-mm-yyyy)	Date member returned to modified work (dd-mm-yyyy)																
If applicable, please describe modifications																	
Employment class (check all that apply) <table style="width:100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Full-time</td> <td><input type="checkbox"/> Permanent</td> <td><input type="checkbox"/> Hourly</td> <td><input type="checkbox"/> Union</td> </tr> <tr> <td><input type="checkbox"/> Part-time</td> <td><input type="checkbox"/> Contract</td> <td><input type="checkbox"/> Salaried</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Temporary</td> <td><input type="checkbox"/> Commissioned</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Seasonal</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Full-time	<input type="checkbox"/> Permanent	<input type="checkbox"/> Hourly	<input type="checkbox"/> Union	<input type="checkbox"/> Part-time	<input type="checkbox"/> Contract	<input type="checkbox"/> Salaried			<input type="checkbox"/> Temporary	<input type="checkbox"/> Commissioned			<input type="checkbox"/> Seasonal		
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<input type="checkbox"/> Part-time	<input type="checkbox"/> Contract	<input type="checkbox"/> Salaried															
	<input type="checkbox"/> Temporary	<input type="checkbox"/> Commissioned															
	<input type="checkbox"/> Seasonal																
What is the regular number of hours per week? _____																	

Is the member involved in shift work? No Yes If yes, provide details of the actual rotation schedule for the three months prior to the disability date and the planned schedule for the claimed disability period.

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4 Coverage information

Date member's Short-Term Disability coverage became effective with Sun Life (dd-mm-yyyy)	Date member's Long-Term Disability coverage became effective with Sun Life (dd-mm-yyyy)
Was the member's coverage in force on the last day worked? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, please provide date and reason (e.g. layoffs)	

5 Earnings and benefit information

Member's regular salary at the last date worked \$ _____ per week	Less Federal/Provincial income tax \$ _____
Date this salary became effective (dd-mm-yyyy)	Last day member's salary was paid (dd-mm-yyyy)
Average monthly commissions earned in the last 24 months. \$ _____	If applicable, please provide a copy of the tax information slips issued for the past two years for this commissioned member.
Total personal income tax exemptions according to the last TDI form (Federal) \$ _____	Total personal income tax exemptions according to the last TP-1015-3V form (Quebec residents only) \$ _____
Social Insurance Number	

1. Is the plan under which this member is covered taxable? No Yes

If yes, please provide the Social Insurance Number above for the member as it is required for the issuance of the applicable tax information slip(s).

2. As of the last day worked, what province of employment were you using for this member's payroll deductions?
Please provide the year to date deductions for:

Employee's CPP \$ _____	Employee's second CPP \$ _____	EI \$ _____
Employee's QPP \$ _____	Employee's second QPP \$ _____	QPIP \$ _____

If the member is exempt from income tax, CPP/QPP, EI/QPIP deductions, please provide appropriate documentation supporting this exemption.

3. Did the member have any scheduled vacation days after the last day worked? No Yes

If yes, how many days? _____

4. Does the member have unused sick leave? No Yes If yes, how many days? _____

5 Earnings and benefit information (continued)

5. What income, if any, does the member receive from you during the absence? Please provide dates and amounts.

How long will this income continue?

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What income, if any, does the member receive (or will receive) during the course of this claim from your retirement or pension plan?

6. Is the member entitled to any other benefits from any other source (e.g. WCB/WSIB/CSST/PPP/QPP)?

No Yes If yes, please describe.

From what date?

Date (dd-mm-yyyy)

7. If the disability is due to pregnancy, has or will the member receive any maternity leave? No Yes

Date maternity leave begins

Date (dd-mm-yyyy)

Date maternity leave ends

Date (dd-mm-yyyy)

8. Are modified duties available? No Yes

Were modified duties offered? No Yes If yes, please describe duties (part-time/full-time/modified).

Did the member accept modified duties if offered? No Yes If no, please provide details below.

6 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
Authorized signature X		Date (dd-mm-yyyy)
Telephone number	Fax number	

6 Declaration (continued)

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 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.

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

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