

Plan Sponsor's Statement Claim for Long-Term Disability benefits *SunAdvantage*



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.

Part 1: Employment and coverage information

1 Plan Member information

Sun Life must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety and submit it at least 8 weeks before the end of the elimination period 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

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

3 Employment information (continued)

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

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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)			
<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		
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

Original effective date of member's basic LTD coverage (dd-mm-yyyy)	Original effective date of optional LTD coverage (if any) (dd-mm-yyyy)
Effective date of member's basic LTD Coverage with Sun Life (dd-mm-yyyy)	Effective date of member's optional LTD Coverage with Sun Life (dd-mm-yyyy)
Coverage class (if any)	Was the member required to submit evidence of insurability? <input type="checkbox"/> No <input type="checkbox"/> Yes

1. Has LTD coverage ended? No Yes If yes, when?

Date (dd-mm-yyyy)

2. Have LTD premiums ended? No Yes If yes, when?

Date (dd-mm-yyyy)

3. Is Cost of Living Adjustment(COLA) Applicable? No Yes

Please complete in reference to Group Life coverage

Is the member presently insured for Group Life coverage that provides for "Waiver of Premium" while on disability under any Sun Life group contract? No Yes If yes, please provide copies of all enrolment cards and/or enrolment forms that the member has signed for all Life benefits.

Contract number	<input type="text"/>	Effective date	<input type="text"/>
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4 Coverage information (continued)

Type of Group Life coverage (complete only if enrolment cards and/or enrolment forms are not available)

Type of coverage	Amount of coverage	Date coverage first became effective (dd-mm-yyyy)	Date coverage last increased (If applicable) (dd-mm-yyyy)
Basic employee life	\$		
Basic dependent life	\$		
Optional employee life	\$		
Optional spousal life	\$		
Optional child life	\$		
Optional employee AD&D	\$		
Optional spousal AD&D	\$		
Optional child AD&D	\$		

5 Earnings and benefit information

If the plan member is tax exempt and the benefit is taxable, please provide a copy of the documentation supporting their tax exempt status.

Current annual insured salary (as of the last day worked) (excluding overtime, commissions and bonuses)		
\$		
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. Did the member have any scheduled vacation days after the last day worked? No Yes

If yes, how many days? _____

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

Date (dd-mm-yyyy)

4. Up to what date was (or will) the member's salary be paid?

5. Does the member currently receive remuneration from you? No Yes If yes, answer a) and b) below.

a) How much? \$ _____ per month Does this amount include unused sick leave? No Yes

Date (dd-mm-yyyy)

b) Until what date will remuneration continue (including sick leave credits)?

6. According to your records, what is the LTD benefit amount? \$ _____ per month

7. To your knowledge, has the member applied for any disability/retirement benefits from CPP, QPP or any other government sponsored plan? No Yes

If yes, select benefit type: Disability Retirement

8. Does the member belong to a retirement or superannuation plan?

No Yes If yes, Registration number _____

5 Earnings and benefit information (continued)

9. Is the member eligible for early retirement pension? No Yes If yes, give details below.

<input type="checkbox"/> reduced pension	On what date?	<input type="text" value="Date (dd-mm-yyyy)"/>	Amount \$ <input type="text"/>
	Has the member applied?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> unreduced pension	On what date?	<input type="text" value="Date (dd-mm-yyyy)"/>	Amount \$ <input type="text"/>
	Has the member applied?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> medical pension	On what date?	<input type="text" value="Date (dd-mm-yyyy)"/>	Amount \$ <input type="text"/>
	Has the member applied?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

6 Workers' Compensation

1. If the member's illness or injury is work related, have they applied for Workers' Compensation benefits?

No Yes If yes, please continue.

What is the claim number? How much is the benefit per month? \$

What is the effective / first payment date?

2. Has the member received a permanent disability award?

No Yes If yes, when did they receive it?

Was it a monthly benefit? No Yes If yes, what was the amount? \$

Was it a lump sum settlement? No Yes If yes, what was the amount? \$

3. If the member's claim has been denied or terminated, have they appealed the decision?

No Yes If yes, when did they appeal it?

Please indicate the stage of the member's appeal (if known).

Oral Board of review Medical panel Medical review Other _____

7 Declaration for Part 1

I certify that the statements in Part 1 of 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		

Part 2: Information about the member's disability and job

1 Plan Member information

First name		Last name	
Date of birth (dd-mm-yyyy)	Contract number		Member ID

2 Information about the disability and rehabilitation

Attach extra sheets, if necessary.

This section asks for information on the member's specific job duties. This part should be completed by the member's immediate supervisor. If there is a prepared job description, please attach it to this form.

1. From your observations did the member's ability to perform his or her job change?

Date (dd-mm-yyyy)

2. When did the member's illness or injury first appear to affect his or her work?

3. Were any changes made in the member's job as a result of the illness or injury?

No Yes If yes, what were the changes and when were they made?

4. Are modified duties available? No Yes

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

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

3 Recent job history

1. On the last day worked, what was the member's:

Job title	Occupation
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Years	Months
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2. How long has the member worked in this position?

3. How many hours per week was the member scheduled to work as of their last day worked?

hours per week

3 Recent job history (continued)

4. If the member changed occupations or assignments during the 12 months immediately before the last day worked, describe the previous occupation or assignment, give reason for the change and the effective date of the change.

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5. Has the member been absent from work due to sick leave, maternity/parental leave or lay-off during the 12 months before the disability began?

No Yes If yes, please provide dates and details.

Type of leave	Details	Beginning date (dd-mm-yyyy)	End date (dd-mm-yyyy)

4 Work environment and job activities

If there is a prepared job description or physical demands analysis for the member's job, please include it with this form.

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

Outside	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %
In extremes of cold or heat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %
In a damp or humid environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %
In a noisy environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %
In a dusty or unventilated environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %
Around toxic fumes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input style="width: 80%;" type="text"/> %

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	<input type="checkbox"/>				
More than 20 lbs/9.1 kg	<input type="checkbox"/>				
More than 10 lbs/4.5 kg	<input type="checkbox"/>				

4 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	<input type="checkbox"/>				
Climbing	<input type="checkbox"/>				
Driving:	<input type="checkbox"/>				
Daytime	<input type="checkbox"/>				
Nighttime	<input type="checkbox"/>				
Reaching:	<input type="checkbox"/>				
Above shoulder height	<input type="checkbox"/>				
At shoulder height	<input type="checkbox"/>				
Below shoulder height	<input type="checkbox"/>				
Bending or crouching	<input type="checkbox"/>				
Kneeling or crawling	<input type="checkbox"/>				

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Number 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
%	%	%

4 Work environment and job activities (continued)

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

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Please indicate if there are any known workplace issues.

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5 Additional remarks

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

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6 Declaration for part 2

I certify that the statements in Part 2 of 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	

If you have access to our Group Benefits Absence & Disability web portal, you can submit completed forms electronically through the portal.

Alternatively, 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.

If you live in the Atlantic provinces, Quebec or Ottawa

For all other provinces or territories

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

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