

Attending Physician's Statement Disability Claim SunAdvantage™



Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada ("Sun Life") in making a decision on your patient's claim for disability benefits. The term "claim" as used throughout this statement relates to the assessment of the plan member's absence from work under the Short-Term Disability (STD) plan and where applicable, the member's absence from work under the Long-Term Disability (LTD) plan.

Return address

For patients who live in the Atlantic provinces, Quebec or Ottawa

Montreal:

Fax: 1-866-639-7846

PO Box 11037 Stn CV

Montreal QC H3C 4W8

For all other provinces or territories

Kitchener - Waterloo:

Fax: 1-866-209-7215

PO Box 100 Stn C

Kitchener ON N2G 3W9

1 Plan Member information and authorization to be completed by patient

Last name		First name		Home telephone number	Alternate telephone number
Address (street number and name)					Apartment or suite
City			Province	Postal code	
Plan Sponsor name			Contract number	Member ID number	
Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)	

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim 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.

Member's signature X	Date (dd-mm-yyyy)
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2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Section 2 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete all sections in full.

Diagnosis	
Primary:	
Secondary:	
If childbirth: expected or actual delivery date (dd-mm-yyyy) <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	

Occupational illness/injury Is condition arising from employment? Yes No

Start dates of current work absence	Date of first visit during current period of absence (dd-mm-yyyy) _____
	First date of work absence due to condition (dd-mm-yyyy) _____

2 Attending Physician's Statement (continued)

Hospitalization

Has your patient been hospitalized Yes No Date admitted (dd-mm-yyyy) _____

Have they had day surgery? Yes No Date discharged (dd-mm-yyyy) _____

Name of institution: _____

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy) _____ Description _____ Type of anaesthetic _____

Treatment (Drug, dosage, physiotherapy, other)

Prognosis — Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History — Has the patient been treated for this condition in the past? Yes No If Yes, date(s) (dd-mm-yyyy) _____

Visits — Frequency of visits Weekly Monthly Other _____

Symptoms — Describe current symptoms, severity and frequency.

Investigations — Please attach copies of all relevant:

- Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)

- Consultation reports

Please note that Genetic testing information is not required, so please do not include.

Are tests/investigations pending? Yes No If Yes, expected date of receipt (dd-mm-yyyy) _____

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit (dd-mm-yyyy) _____

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

Complications and other condition(s) — Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment — To your knowledge, is the patient following the recommended treatment program? Yes No

Competency — In your opinion, is your patient competent to manage his/her own affairs? Yes No

Prognosis — Please provide the prognosis for recovery (if not completed on page 1)

4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Last name of attending physician (please print)	First name	Certified specialist		Physician's stamp
Address (street number and name)				
City		Province	Postal code	
Telephone number	Fax number			
Physician's signature X				
				Date signed (dd-mm-yyyy)
NOTE: Your patient is responsible for any charge made for the completion of this form.				



Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.