

Accommodation Services Plan Sponsor Referral Form



In this form, when we refer to Sun Life, we're including our agents and service providers.

Accommodation Services will provide you with a one-time assessment of a plan member's accommodation request. This is for plan members who are at work and asking for an accommodation to stay at work. Through this service, Sun Life will arrange for a consultation to be provided by a third-party service provider.

This form gives us the information needed for the accommodation assessment. Please complete this form in its entirety to avoid delays.

To request Accommodation Services, please:

- Provide the plan member with the Accommodation Services Plan Member Statement and ask them to complete and return it to you.
- Complete the Accommodation Services Plan Sponsor Referral Form (this form) in its entirety. It gives us the information needed for the accommodation assessment. Submit this form to Sun Life with the Plan Member Statement.
- Provide the plan member with the Accommodation Services Attending Physician Statement, to complete with their doctor. The plan member will send the Attending Physician Statement directly to Homewood Health once completed.

Sun Life commits to keeping plan members' personal information confidential. This statement forms part of the plan member's accommodation services file. We will release this statement to the plan member if they request their file.

1 Fees

If there are additional fees related to this case, you'll be advised ahead of time and will provide approval.

2 Employee Information

First name	Last name	Date of birth (dd-mm-yyyy)	
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Home phone number	Alternate phone number		
Plan Member's work email address, if applicable	Regular occupation title/Job name		

3 Employer information

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

4 Accommodation information

Is there currently an accommodation in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> temporary <input type="checkbox"/> permanent	Was there a previous accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide date (dd-mm-yyyy)
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Please describe, to the best of your knowledge, the reason for the request for accommodation and any details you may have about the plan member's current situation.

Please describe any modifications that you currently have in place or previously attempted

5 Employment information and job activities

This section asks for information on the employee's specific job duties. We need this part to be filled out by the plan members immediate supervisor or another person who can identify the plan members specific job duties. If there is a prepared job description, Physical Demands Analysis or Cognitive Demands Analysis please attach it to this form.

Date member started with the company (dd-mm-yyyy)

Employment class (check all that apply)

<input type="checkbox"/> Full-time (25 hours per week or more)	<input type="checkbox"/> Part-time	Regular number of hours per week _____
<input type="checkbox"/> Permanent	<input type="checkbox"/> Contract	<input type="checkbox"/> Temporary
<input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried	<input type="checkbox"/> Seasonal
		<input type="checkbox"/> Commissioned
		<input type="checkbox"/> Union

What is the plan member's regular work schedule? If this varies, please provide a sample work calendar

1. Is the plan member's job a safety sensitive position? No Yes Unknown

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

Outside No Yes If yes, what percentage of time? %

In a noisy environment No Yes If yes, what percentage of time? %

In a dusty or unventilated environment No Yes If yes, what percentage of time? %

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

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

5 Employment information and job activities (continued)

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. 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

Does the plan member have to analyze complex data? Yes No

Is the plan member responsible for reading simple to complex information? 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
%	%	%

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

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6 Other remarks

Are there any workplace factors that may impact the accommodation? Yes No

Provide any comments or other remarks.

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7 Declaration

I am authorized to complete this form on the plan sponsor's behalf. I certify that the statements in this form are true and complete. In place of my handwritten signature, I have typed my name. Both my typed name and an electronic copy of this form are as valid as an original.

Last name of member's supervisor (please print)	First name	
Phone number	Email address	
Last name of person signing this statement (please print)	First name	
Position of person signing this statement (please print)		
Signature X		Date (dd-mm-yyyy)
Phone number	Email address	

Please send the completed Plan Sponsor Referral Form along with any supporting documents you may have to review the details of the accommodation request (e.g., medical certificate, job description, etc.), along with the Plan Member Statement, completed by the plan member.

If you have access to our Disability Online Tool, you can use it to submit completed forms electronically.

If you don't have access to the Disability Online Tool, you can send information by email at disabilityclaims@sunlife.com. If you choose to send your information by email, we can't guarantee the privacy or security of email communications while they're on their way to us.

Please retain the original copy for your records.