Claim for Disability Insurance
Employee's Statement
Policy No. 12500-G

Sun Life Financial

Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

Clear

1 Employee information

In order to avoid any delays in the assessment of your claim, please complete this form in its entirety and submit it by fax or email, ideally at least 60 days before the end of the elimination period but no later than 90 days after the end of the elimination period in order to avoid delays. **If a claim form is submitted later than 90 days after the end of the elimination period, you may not be entitled to Disability Insurance Plan benefits if the delay impedes Sun Life's ability to assess the claim.** See submission instructions at the end of the form. We also require the Compensation Advisor's, the Employer's Statements and Attending Physician's Questionnaire to be submitted within the same time frame. **Any cost for information to substantiate this claim will be your responsibility.**

Your disability benefits under your Long-Term Disability Insurance Plan are taxable, therefore your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name (Quebec residents – maiden name)	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (streen number and name)			Apartment or suite
City		Province	Postal code
Occupation	Social Insurance Number		
Home telephone number	Alternate telephone number	Preferred language of correspondence ☐ English ☐ 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 email communication cannot be guaranteed.

Email address

2 Employer information

Certificate number CG	Department or organization name	
Name and title of immediate supervisor	Immediate supervisor's telephone number	Ext.
Immediate supervisor's email address		

Telephone contact

When Sun Life receives your claim, you may receive a phone call from the individual responsible for its assessment. This will be your opportunity to discuss and clarify any issues relating to your claim. (Please note: it may be determined that a call is not required.)

3 About your illness or injury

1. Please describe your present illness or injury.

2. Describe how illness or injury occurred.

3. When did your symptoms first appear? Date (dd-mm-yyyy)

4. Have you ever had the same or similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

5a. On what date did you first see a doctor for this illness or injury? Date (dd-mm-yyyy)

5b. If there was a delay in seeking treatment please explain.

6. From what date did your illness or injury prevent you from working at your own occupation? Date (dd-mm-yyyy)

7. If you remain actively at work but have reduced hours due to illness or injury, please indicate the effective date of the reduced work schedule. Date (dd-mm-yyyy)

8. What treatments are you presently receiving (medicinal, dietary, advice from a doctor, physiotherapy, etc.)?

3 About your illness or injury (continued)

9. 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. **Please provide us with any test results, physician/specialist reports and/or investigations you may have.** If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

Doctor	Address	Date of visit (dd-mm-yyyy)

4 Your general medical history

Attach extra sheets, if necessary.

1. Please list names and addresses of all hospitals where you have been treated during the past three years, including any type of surgery.

Hospital	Address	Nature of illness/injury	Date (dd-mm-yyyy)

2. List all the doctors you have seen during the past three years for any other illness or injury.

Doctor	Address	Nature of illness	Date (dd-mm-yyyy)

5 Illness or injury as a result of an accident

1. Is your illness or injury the result of an accident other than a workplace accident?

☐ No If no, please proceed to Section 6.

☐ 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?

☐ No ☐ Yes If yes, please ensure you complete section 6, "Workers' Compensation".

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 Illness or injury as a result of an accident (continued)

3. If your illness or injury is the result of an accident, are you taking legal action against any other person or organization?

☐ No If no, explain why you are not taking legal action.

☐ Yes If yes, please complete the following:

Name of your lawyer		Telephone number	
Address	City	Province	Postal code

On what date did the legal action start? Date (dd-mm-yyyy)

Has a settlement been reached? ☐ No ☐ Yes If yes, please attach a copy of the terms of the settlement and any related documents.

6 Workers' Compensation

1. If your illness or injury is work related, have you applied for Workers' Compensation benefits? ☐ No ☐ Yes If no, please explain.

2. Are you receiving, or do you expect to receive, Workers' Compensation benefits? ☐ No ☐ Yes If yes, please continue.

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

3. Have you received a permanent disability award?

☐ No ☐ Yes If yes, when did you receive it? Date (dd-mm-yyyy)

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? $

4. If your claim has been denied or terminated, have you appealed the decision?

☐ No ☐ Yes If yes, when did you appeal it? Date (dd-mm-yyyy)

Please indicate the stage of your appeal (if known).

☐ Oral ☐ Board of review ☐ Medical panel ☐ Medical review ☐ Other _____

7 Canada/Quebec Pension Plan Benefits

1. Have you applied for any disability/retirement benefits from Canada/Quebec Pension Plan? ☐ No ☐ Yes

   If yes, when did you apply? Date (dd-mm-yyyy)

2. What type of CPP/QPP benefits did you apply for? ☐ Disability ☐ Retirement

3. If you have applied, what is the status of your application?

   ☐ Waiting for the decision

   ☐ Approved Please include a copy of the CPP/QPP documentation.

   Benefit effective date: Date (dd-mm-yyyy) Benefit amount per month: $

   ☐ Denied Please provide a copy of the denial letter.

   If denied, have you appealed the decision?

   ☐ No ☐ Yes If yes, please provide the date of the appeal: Date (dd-mm-yyyy)

Please provide any additional details regarding your application/appeal.

8 Your other income

Please list any amounts of money you are currently receiving or expect to receive each month from the following sources. We may take some of these amounts into consideration when we calculate your Long-Term Disability benefit.

Source	Insurance Co. & Policy number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per ☐ Week ☐ Month	When are our benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. Creditor, etc.)		☐	☐	☐	☐	$	
Auto Insurance		☐	☐	☐	☐	$	
Other Group/Association/Individual Plans		☐	☐	☐	☐	$	
Employment Insurance		☐	☐	☐	☐	$	
Quebec Parental Insurance Plan		☐	☐	☐	☐	$	
Canada/Quebec Pension Plan		☐	☐	☐	☐	$	
Public Service Superannuation Act (PSSA)		☐	☐	☐	☐	$	
Other (specify) i.e. in Quebec, Criminal Victims Benefits		☐	☐	☐	☐	$	

9 Returning to work

You must notify Sun Life 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.

Returning to work is an important part of your treatment program. If you qualify, Sun Life has a program to assist you to return to work. You may be contacted by a Sun Life Health Management Consultant.

9 Returning to work (continued)

1. 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 Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

   Did you return to: ☐ your own occupation ☐ new occupation or modified duties

   Did you return to: ☐ full-time ☐ part-time

2. When do you expect to be able to return to your own occupation? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

3. When do you expect to be able to do any other occupation? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

4. Have you discussed returning to work with your doctor? ☐ No ☐ Yes
   If yes, please give details including recommended change in, or certain restrictions on, the type of work that you could do.

5. What discussions have you had with your employer regarding your return to work, either to your own occupation (with or without modification), or to another position?

6. Have you been involved in any activities for which you have received money since you became disabled? ☐ No ☐ Yes
   If yes, please give details.

7. List the duties of your occupation you are unable to perform because of your illness/injury.

8. List the duties of your occupation you are able to perform.

10 Your education, skills and work history

1. Level of education completed: ☐ High School ☐ Community College ☐ University
   What was the highest grade level/year that you completed? Please list any certificates/degrees obtained.

10 Your education, skills and work history (continued)

2. Please describe other educational training or skills upgrading (include on-the-job training, special interest courses, etc.). In addition, list any other skills you have acquired. These skills may include typing, computer skills, operation of equipment, supervisory skills, special licenses, etc. They may also include skills acquired through volunteer work, hobbies and interests. (Attach extra sheets, if necessary.)

3. Do you have a valid driver's license? ☐ No ☐ Yes If yes, Class

Please give details about any driving restrictions resulting from your disability.

Please describe your work history including the last three positions you held.

Attach a resume if available.

From (date) (dd-mm-yyyy)	To (date) (dd-mm-yyyy)	Employer	Job title

11 Automatic deposit of your disability payments *(This service is subject to the approval of your claim.)*

If disability benefits are authorized, your benefit payments will be directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. In order to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

This sample cheque shows the information that you need to provide.

Notes:

Branch/Transit numbers are normally 4-5 digits

Bank/Institution numbers are always 3 digits long:

BMO 001

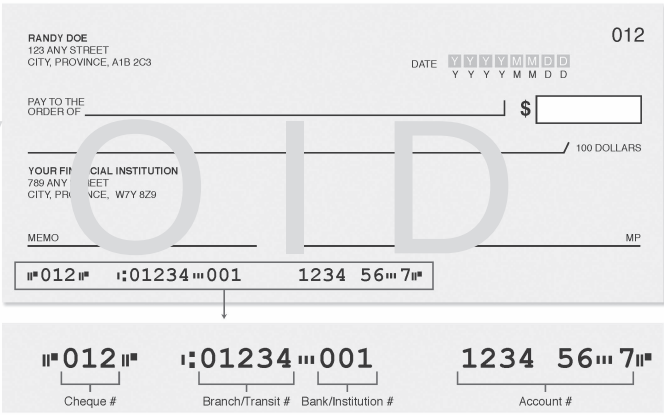
Scotiabank 002

RBC 003

TD 004

CIBC 010

Account numbers can be up to 12 digits long



12 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan and we will verify the accuracy of the information given in support of your claim.

You must also sign and complete the Member's Authorization on the Attending Physician's Questionnaire.

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 claim. I authorize Sun Life and its reinsurers to collect, use and disclose information needed for underwriting, administration, adjudicating claims under this Plan to any person or organization who has relevant information pertaining to my claim 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 claim for purposes relevant to the management of this Plan. I understand that information about me pertaining to my claim may be reviewed in the event this Plan is audited.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that my consent is valid for the duration of my claim, 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 Assurance Company of Canada or the 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

Member's signature	Date (dd-mm-yyyy)
X	

13 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.

You can 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. If you are unable to fax this information, you can mail it to the appropriate address. If you choose to do so, please keep a copy for your records.

Fax: 1-866-639-7849

Montreal Group Disability Management Office
Federal Government Disability Insurance Plan
Sun Life Assurance Company of Canada
P.O. Box 12500 Station CV
Montreal, QC H3C 5T6

14 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.