Salary Continuance Services
Plan Sponsor Package

How to use this package:

REVIEW	• The link below will take you to the Plan Sponsor's Statement. The "Return to Introductory Page" link within the form will take you back to this page.
COMPLETE	• You are able to save information typed into the form.. • Complete the Plan Sponsor's Statement in its' entirety.
SUBMIT	**FAX** • Print the completed Plan Sponsor's Statement (pages 2 - 5) and sign the Declaration at the end of the form. • Fax the form to the Sun Life Group Disability Management office that manages your absences. You do not need to mail information that you fax. Please retain the original copy for your records. **EMAIL OPTION** • Contact your Service Representative for information on how to register your email domain for Transport Layer Security (TLS) e-mail submission. • Sun Life will not accept the confidential information contained on these forms by email unless TLS secured electronic submission is set-up.

Plan Sponsor's Statement for Salary Continuance Services

Plan Sponsor's Statement
Salary Continuance Services

Sun Life

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 salary continuance claims file. We will release this statement to the plan member if they request their file.

Please check service option being requested

- ☐ Full Case Management
- ☐ Return to Work Advisory Services **(one-time assessment)**
- ☐ Chronic Casual Absence Services **(please provide attendance records for last six months)**
- ☐ Service Provider Network

Clear

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 absence. Please complete this form in its entirety in order to avoid delays.

First name	Last name	☐ Male ☐ 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

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)

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 one box in each row)

a) ☐ Full-time ☐ Part-time How many hours per week? _____
b) ☐ Permanent ☐ Contract ☐ Temporary ☐ Seasonal
c) ☐ Hourly ☐ Salaried ☐ Commissioned
d) ☐ Union

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.

4 Coverage Information

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? ☐ No ☐ Yes If *no*, please provide date and reason (e.g. layoffs)

5 Work environment and job activities

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

Outside	☐ No	☐ Yes	If yes, what percentage of time?	%
In extremes of cold or heat	☐ No	☐ Yes	If yes, what percentage of time?	%
In a damp or humid environment	☐ 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?	%
Around toxic fumes	☐ No	☐ Yes	If yes, what percentage of time?	%

2. Does the plan member's job involve handling chemicals? ☐ No ☐ Yes If yes, please list the chemicals below.

5 Work environment and job activities (continued)

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	☐	☐	☐	☐	☐
More than 20 lbs/9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs/4.5 kg	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

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	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐

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	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Driving	☐	☐	☐	☐

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: ☐

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5 Work environment and job activities (continued)

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.

6 Additional remarks

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

7 Declaration

I certify that the statements in this form are true and complete.

Last name of member's supervisor (please print)	First name
Telephone number	Fax number
Last name of person signing this statement (please print)	First name
Position of person signing this statement (please print)	
Authorized signature X	Date (dd-mm-yyyy)
Telephone number	Fax number

To ensure prompt submission, please fax this form, along with any other information you may receive from the member, to the number that appears below for the Sun Life Group Disability Management Office that manages your absences.
If you are unable to fax this information, you can mail it to the appropriate address. You do not need to mail information that you fax.

Halifax:
Fax: 1-866-639-7850
PO Box 11480 Stn CV
Montreal QC H3C 5P5

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

Toronto:
Fax: 1-866-639-7851
PO Box 950 Stn A
Toronto ON M5W 1G5

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9

Edmonton:
Fax: 1-866-639-7820
PO Box 2733 Stn Main
Edmonton AB T5J 5C9

Vancouver:
Fax: 1-866-639-7829
PO Box 48810 Stn Bentall
Vancouver BC V7X 1A6