Sun Life Financial

PLAN MEMBER CONFIRMATION OF ILLNESS
For new STD, Early*RETURNS* and SunAdvisor claims

Please complete this form only if your absence is due to flu-like illness or if you have a clinical diagnosis of H1N1.

In recognition of the increasing pressure on our medical clinics and hospitals due to the H1N1 pandemic, we will not, at the outset, require an Attending Physician's Statement as part of your Short Term Disability claim submission if your absence is due to flu-like symptoms or a clinical diagnosis of H1N1. This is a time-limited exception as we move through the 2009-2010 flu season.

In the absence of an Attending Physician's Statement, we require confirmation of your symptoms and any medical treatment you may have received for your condition. Accordingly, please complete and sign this form and return it with your Plan Member Statement to the appropriate Sun Life Assurance Company of Canada Group Disability Management office.

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1. Please confirm: Date symptoms first appeared: _____ (dd/mm/yyyy) First day absent from work: _____ (dd/mm/yyyy)

2. Please indicate the symptoms associated with your illness:

☐ Fever	☐ Decreased appetite	☐ Nausea
☐ Cough	☐ Runny nose	☐ Vomiting
☐ Fatigue	☐ Muscle aches	☐ Headache
☐ Sore throat	☐ Other _____	

3. Do you have any other health problems that might affect your recovery?

_____

4. What medical attention have you sought for your symptoms?

☐ None at this time – I'm following public health recommendations to stay at home.
☐ I've called my provincial public health line, flu clinic or doctor's office for a telephone consultation.

Date(s) of consultation _____

Name of service/clinic _____

☐ I have seen my physician, or have gone to a clinic/hospital for assessment.

Date(s) of visit _____

Physician's name or name of clinic/hospital _____

5. What advice were you given regarding managing your illness and/or what treatment did you receive?

_____

_____

6. When did you return to work? _____ (dd/mm/yyyy) Or expect to return? _____ (dd/mm/yyyy)

I certify that the statements in this form are true and complete and understand that further information may be required to validate my claim.

Name: _____ Phone #: _____ Cell #: _____

Signature: _____ Date: _____

Contract Number: _____ Member ID: _____

For more information on flu and the H1N1 flu virus, go to www.fightflu.ca or the Public Health Agency of Canada's website at http://www.phac-aspc.gc.ca/index-eng.php.

Group Benefits are provided by Sun Life Assurance Company of Canada