Long-Term Disability
Plan Member Package

How to use this package:

REVIEW	• The links below will take you to the Long-Term Disability (LTD) Claim Guide, a Plan Member's Statement and an Attending Physician's Statement included in this package. The "Return to Introductory Page" link on each document will take you back to this page. • The LTD Claim Guide is designed to answer questions you may have regarding the claim submission process. • Read the Authorizations on both the Plan Member's Statement and Part 1 of the Attending Physician's Statement.
COMPLETE	• You are able to save information typed into the forms included in this package. • Complete the Plan Member's Statement in its' entirety. • Complete Part 1 (Plan Member Information) of the Attending Physician's Statement.
PRINT	• Print the completed Plan Member's Statement (pages 10 - 16) and sign the Authorization. • Print the Attending Physician's Statement (pages 17 - 20) with Part 1 completed, sign the Authorization and have your physician or specialist complete the form in its entirety.
SUBMIT	• Fax the forms, along with any other information in support of your absence that you would like to submit, to the Sun Life Canada Group Disability Management office that manages your claims. You do not need to mail information that you fax. Please retain the original copy for your records. • Alternatively, you can mail your information to the appropriate office. • If you are not sure which office to send your information to, please contact your Benefits Administrator.

- Long-Term Disability Claim Guide
- Plan Member's Statement for Long-Term Disability Benefits
- Attending Physician's Statement for Long-Term Disability Benefits

Life's brighter under the sun

Sun Life Financial

Long-Term Disability

Claim Guide

Life's brighter under the sun

Sun Life Financial

Return to Introductory Page

Long-Term Disability (LTD) coverage provides benefits to you when you are disabled. This guide is designed to help you through the claim submission process and to answer any initial questions you may have with respect to filing a claim for Long-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.

Return to Introductory Page

Reporting your absence

To apply for LTD benefits, you and your employer will need to send us a completed LTD form package. The package contains three forms:

- A Plan Sponsor's Statement, which your employer completes and faxes to us;
- A Plan Member's Statement (obtained from your plan sponsor), which you must complete and fax to us at the fax number shown on the form. If you are unable to fax this information, you can mail it to the closest Sun Life address on the form.
- An Attending Physician's Statement (obtained from your plan sponsor), which you take to your doctor to complete and fax to us. NOTE: Your doctor may charge you a fee to complete this form. If so, you will be responsible for paying that fee.

1. Complete the Plan Member's statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence, and include a detailed job description and resume with previous job experience and education history. (You can attach extra paper to the form if you need more space.)
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Please provide the required document outlined in the *"Automatic deposit of your disability payments"* section if you would like to have your payments deposited into your bank account. For chequing accounts, we will require a personalized VOID cheque.
- Please read and sign the Declaration and Authorization which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. Also, please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.

2. Have your physician complete the Attending Physician's Statement

This statement provides us with specific medical information about your condition and your expected recovery.

- Your doctor's Attending Physician's Statement must provide a diagnosis and prognosis for your condition. (This form can be completed by your family doctor, a doctor at a walk-in clinic, a specialist, etc – any medical professional who is a doctor of medicine and that has treated you for your condition.)
- If your doctor conducts tests, all of the findings must be included on or with the Statement.
- If you have seen a specialist for your condition, be sure to have your physician send us copies of all consultation and clinical notes with the Statement. (Often, we must follow up to request these documents which can delay the assessment of your absence.)

NOTE: Do not change or write anything on the Attending Physician's Statement. Any changes to the Statement must be initialed by your doctor.

3. Sending your LTD claim package

- Follow up with your doctor and employer to confirm they have completed, signed and faxed us their Statement forms. We cannot assess your claim until we receive all three forms from you, your employer and your doctor.
- We recommend you submit the completed claim forms at least eight weeks prior to the first payment date of your LTD. This provides us with sufficient time to review your claim and obtain any additional information we may require to complete our assessment for benefits.
- Faxing your forms, using our secured fax numbers, is the fastest way to get your forms to our office. It is also convenient as you do not need to mail information that you send in by fax, so you will have a copy for your records. If you are not sure which fax number to send your information to, please contact your Benefits Administrator.

Be sure your group Contract number and your Member ID number are clearly shown on your Plan Member's Statement and Attending Physician's Statement before faxing/mailing. If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.

When we receive your claim

Our Abilities Case Manager will consider a number of different factors when assessing the information we receive about your claim. We look at the medical information, information about your ability to function and carry on daily living activities, your occupational demands, your work environment and how your illness would affect your ability to perform the demands of your occupation.

As part of this review, we will be contacting you to conduct a telephone interview to ask some further questions and this will also give you the opportunity to ask your own questions about your claim. We may also need to contact your doctor and/or your employer by phone to ask some further questions or obtain any missing information.

We'll let you know

The claims assessment process usually takes about 10 business days after we receive all the necessary information. If we determine that your claim is approved according to your employer's LTD plan, we will notify you and your employer in writing that we have approved your claim. Likewise, if we find that your claim is not approved, we will notify you in writing and provide the reasons for our decision.

For some claims, we may determine that we don't have enough information to make a proper decision. In such a case, we try to get the additional information we need as effectively and efficiently as possible. This might involve an independent medical exam or a separate evaluation of your functional abilities. We will let you know as soon as we determine that more information is needed.

Your information is confidential

We treat the information you provide for your LTD claim as confidential. We will use the information for the initial and ongoing assessment of your claim. It will not be disclosed to other parties, including your employer, without your written consent.

Return to Introductory Page

FAQs

We want you to feel comfortable with the Long-Term Disability claims process. This Frequently Asked Questions guide is designed to help you understand more about the process, from claims submission through to your recovery. This guide is not intended to replace or amend your employee benefits booklet, the terms of which shall prevail over this guide.

What are my Contract, Division and Member ID numbers?

The Plan Member's Statement asks for your Contract number, Member ID and Division/Billing number.
The Contract and Division numbers are specific for your plan sponsor/employer's coverage with Sun Life Financial.
The Member ID number is the number used to identify you specifically. These numbers can be found on your coverage or enrolment summary or in your employee benefits booklet.

What does plan sponsor mean?

The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your plan.

Why should my doctor fill out all the information on my form?

To expedite your claim, it is very important to have all of the information requested. If your doctor provides only part of the information, or a brief note on a doctor's prescription pad, we may not have all of the information needed to assess your request for benefits, or extension of benefits. This will potentially delay a decision on your claim.

What does Waiver of Premium mean?

Some Group Disability plans provide for coverage that waives the premiums required for certain benefits while you are entitled to Disability benefits under the plan. This means that for the period you are considered totally disabled under the plan, you or your employer will not need to pay the premiums for the coverage of these benefits.
Your Benefits Administrator would be able to confirm if your plan has Waiver of Premium coverage. If your plan does contain this coverage, and you are submitting a claim for Long-Term Disability benefits, a claim would automatically be made for any Waiver of Premium benefits that you may be eligible for. You will be advised of the status of your entitlement to the Waiver of Premium benefit along with the status of your LTD claim.

How are my benefits calculated?

Disability benefit payments are usually based on a specific percentage of your monthly earnings at the time you become disabled. The benefit amount under your plan is specified in your employee benefits booklet.

If my claim is approved, when do my payments start?

Your benefit payments will be paid from the date the elimination period is completed. If this date is in the past, then payment will be made for the retroactive amount owing.

How and when are payments made once the claim is approved?

LTD benefits are paid on a monthly basis. You can be paid by cheque or have your benefits deposited directly into your bank account. Having your benefits deposited directly into your bank account helps avoid delays with mailing. The Plan Member's Statement form includes information on what is required in order for payment to be made through a direct deposit. Don't forget to review this section and provide the required documentation. For chequing accounts, we will require a personalized VOID cheque.

NOTE: There may be a delay in payment if a scheduled payment falls on a holiday. Your first payment may be sent to your plan sponsor if they have requested this.

How long will I receive disability payments?

For LTD, you will continue to receive disability payments as long as you meet the definition of total disability as defined in your employee benefits booklet and satisfy other obligations (such as pursuing appropriate treatment) as also described in your benefits booklet. Generally speaking, we consider whether you are 'totally disabled' from your own occupation for a defined period of time following the elimination period. After this period of time, we then consider whether you are 'totally disabled' from any occupation. In the event that you remain continuously and

totally disabled, benefits do not continue indefinitely. Your benefits booklet will refer to other critical dates relating to when your benefits terminate, including the date on which you reach age 65, retire, or die, whichever occurs first.

Please consult your employee benefits booklet for the specific details of your plan.

Why do I need to provide proof of my age?

If not submitted with your original application for LTD benefits, we will request proof of your age as part of the ongoing management of your disability absence. As many plans only provide LTD benefits until age 65, it is important that we confirm the date that this will occur.

What are my responsibilities while I receive disability benefits?

While you are on claim, we will talk to you about returning to work, at the appropriate time. We expect that you will participate in these discussions, and return to your own occupation as soon as it is safe and healthy for you to do so. If it becomes apparent that you will not be able to return to your own occupation, you will be expected to consider any reasonable offer of modified work with your employer and/or participate in any training required to qualify for an alternate occupation.

Once I've been approved for benefits, how often is medical information requested?

A clear understanding of the progress of your recovery is considered essential in preparing for a potential return to work. Periodic updates on your medical condition and functional status help us determine your progress. The frequency of status reports will be determined by the unique circumstances of your claim, your medical condition and treatment plan. We will follow up with you and your treating physician(s) by telephone or mail.

The Abilities Case Manager will work with your doctor and/or our Health Partners to ensure you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam to get more information. We will arrange the appointment and give you adequate advance notice. (We will provide a copy of the results to your treating physician.)

When would benefits not be paid?

Benefits may not be paid if you:

- are not receiving appropriate treatment as recommended by your treating physician
- are not participating in a Sun Life-approved rehabilitation program
- are on leave of absence, strike or lay-off, except where Sun Life specifically agreed to the continuation of coverage or may be required to by law
- are absent from Canada due to any reason, unless you have received written agreement from our Abilities Case Manager in advance to pay benefits during this period
- complete any work for wage or profit except as approved by us
- serve a prison sentence or are confined in a similar institution

Please consult your employee benefits booklet for the specific details of your plan.

What if I receive income from another source? How will that impact my benefit?

Your employer's LTD plan may indicate that your disability benefits are reduced by payments received from other sources, such as CPP/QPP and Worker's Compensation for the same or subsequent disability. Your benefit payment will not be reduced by income you receive from an individual disability plan.

A retroactive award from another source may reduce your disability benefit and may result in an overpayment. If this situation occurs, you are expected to reimburse Sun Life the amount overpaid.

Does Sun Life share medical information with my employer?

No. All medical information obtained by Sun Life concerning your health event is strictly confidential and not shared with your employer.

We will only advise your employer about limitations or restrictions that will affect your ability to perform your occupation, a modified occupation or another occupation with your employer (as outlined in the Authorization you signed on your Plan Member Statement).

What if I return to work with some restrictions?

The Abilities Case Manager and your employer will work with you to develop a return-to-work plan that accommodates your abilities and restrictions. Your return-to-work plan could include, for example, graduated return to work and/or a return to modified or part-time duties to help you adjust. Should your return to work require specific vocational expertise, we will involve one of our Health Management Consultants to assist with coordinating your return to the workplace. We will contact your doctor to ensure he or she is aware of the plan before it begins.

Once you're back to work full-time without restrictions, Sun Life is usually no longer involved.

Will I receive a tax slip?

A tax slip will be issued if the disability benefit payments you receive are taxable income. Tax slips are mailed by the end of February every year, for the previous tax year. If you are unsure if the disability benefits payments you receive are taxable income, please contact your Benefits Administrator.

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than five million people in over 10,000 corporate, association, affinity and creditor groups across Canada. Our core values — integrity, service excellence, customer focus and building value — are at the heart of who we are and how we do business. Our extensive products, services and technology enable us to tailor group benefit programs to meet virtually any customer's needs competitively and cost-effectively.

Sun Life Financial and its partners have operations in key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

www.sunlife.ca

GB10069-E (03-10) kg/cm

Sun Life Financial

Return to Introductory Page

Plan Member's Statement
Claim for Long-Term Disability benefits

Sun Life Financial

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

Clear

1 Plan Member information

In order to avoid any delays in the assessment of your claim, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If disability benefits under your Long-Term Disability Plan are taxable, 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)
Specht	Shayne			09 – 09 – 1973
Address (street number and name)	**Apartment or suite**	**City**	**Province**	**Postal code**
439 Notre Dame Street West		Azilda	ON	P0M 1B0
Occupation	**Job title**		**Social Insurance Number**	
Sand Blaster	Sand Blaster		4 9 0 1 1 9 5 9 1	
Home telephone number	**Alternate telephone number**		**Email address**	
705 – 698 – 0665	– –			

2 Plan Sponsor information

Contract number	Member ID	Division/Billing group number	
22205	902465	Provincial / 01	
Company name			
William Day Construction Limited			
Address (street number and name)	**City**	**Province**	**Postal code**
2500 Elm Street, Box 1060	Azilda	ON	P0M 1B0
Contact person	**Contact's telephone number**		**Ext.**
Alison Taylor	705 – 682 – 1555		2237

3 About your illness or injury

1. Please describe your present illness or injury and how it prevents you from working. Include a description of which duties of your job you are *unable* to perform because of your illness or injury. As well, list the duties of your job you *are* able to perform. (Attach extra sheets, if necessary.)

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

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

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

Return to Introductory Page

3 About your illness or injury (continued)

5. From what date did your illness or injury prevent you from working? Date (dd-mm-yyyy) – –

6. Is your illness or injury work related? ☐ No ☐ Yes If yes, please explain

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

8. 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.

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

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

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

11. 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 job ☐ new job or modified duties

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

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 five years, including any type of surgery.

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

Return to Introductory Page

4 Your general medical history (continued)

Attach extra sheets, if necessary.

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

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

5 Disability as a result of an accident

1. Is your disability the result of an accident?

☒ No If no, continue with the next section **"Workers' Compensation".**

☐ 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 the section "Workers' Compensation".

Please describe how your illness or injury occurred.

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
			– –

3. If your disability 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 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.

Return to Introductory Page

6 Workers' Compensation

1. If your illness or injury is work related, have you applied for Workers' Compensation benefits? ☐ Yes ☐ No 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 a Disability Pension under the Canada/Quebec Pension Plan for you or your dependents?
   ☐ No ☐ Yes If yes, when did you apply? Date (dd-mm-yyyy)

2. If you have applied for a Disability Pension, has your application been approved?
   ☐ Yes If yes, please include a copy of the Notice of Entitlement and Payment Explanation Statement with this form.

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

   ☐ No If no, please provide a copy of the denial letter.

   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.

3. Provide the following information for any dependent children living with you:

Full name	Relationship to you		Date of birth (dd-mm-yyyy)	If child is 18 or over, check whether child is:	
	Son	Daughter		Handicapped	Full-time student
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Return to Introductory Page

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	Are you eligible for this benefit?		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
	Yes	No		Yes	No	Current	Expected	
Any other disability insurance (i.e. WCB/WSIB/CSST, Union Disability Benefit, Creditor, Credit Cards, etc.)	☐	☐		☐	☐	☐	☐	$
Auto Insurance	☐	☐		☐	☐	☐	☐	$
Other Group/Association/Individual Plans	☐	☐		☐	☐	☐	☐	$
Employment Insurance	☐	☐		☐	☐	☐	☐	$
Quebec Parental Insurance Plan	☐	☐		☐	☐	☐	☐	$
Canada/Quebec Pension Plan	☐	☐		☐	☐	☐	☐	$
Employer Disability, Severance or Retirement	☐	☐		☐	☐	☐	☐	$
Any other Accident/Group Association/Government Disability Benefit	☐	☐		☐	☐	☐	☐	$
Other (specify) i.e. in Quebec, Criminal Victims Benefits	☐	☐		☐	☐	☐	☐	$

9 Returning to work

You must notify Sun Life Assurance Company of Canada 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 Assurance Company of Canada has a program to assist you to return to work. You may be contacted by a Sun Life Assurance Company of Canada Health Management Consultant.

1. Have you discussed returning to work with your doctor? ☐ No ☐ Yes If yes, please give details.

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

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

4. Have your normal daily activities been limited in any way? ☐ No ☐ Yes If yes, please give details.

Return to Introductory Page

10 Your education and acquired skills

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.

2. Please advise if your education was obtained within Canada or outside of Canada. If obtained outside of Canada, please confirm where.

3. 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.)

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

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

11 Your work experience

Attach a resume if available.

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

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

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. **If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque.** Please check with your Benefit Administrator to determine if this option is available to you.

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.

13 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.

If you are age 60 or over, please attach a copy of your birth certificate, baptismal record, passport or drivers license as proof of age.

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

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 X		Date (dd-mm-yyyy) – –

To ensure prompt submission, please fax this form, along with any other information in support of your claim that you would like to submit, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

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

Visit our website: www.sunlife.ca/health and work

14 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Attending Physician's Statement
Claim for Long-Term Disability benefits

Sun Life Financial

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

1 Plan Member information

This part of the form should be completed before the physician completes part 2.

Any cost for information to substantiate this claim will be the member's responsibility.

You can mail this form directly to one of our regional claims offices. The office addresses are listed at the end of this form.

Please complete this form in its entirety and return to us as soon as possible. Failure to do so may result in the delay of any payments to the patient.

Contract number: 22205	Member ID: 902465	Division/Billing group number: Provincial / 01	
Last name (Quebec residents – maiden name): Specht	First name: Shayne	☒ Male ☐ Female	Date of birth (dd-mm-yyyy): 09 – 09 – 1973
Address (street number and name): 439 Notre Dame Street West		Apartment or suite:	
City: Azilda	Province: ON	Postal code: P0M 1B0	
Home telephone number: 705 – 698 – 0665	Alternate telephone number: – –	Email address:	
Plan Sponsor name: William Day Construction Limited		Date last worked (dd-mm-yyyy): 13 09 2018	

Member's authorization & signature

I authorize my doctor to collect, use and disclose my personal information to Sun Life Assurance Company of Canada, 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): – –

2 Physician's Information

Sun Life Assurance Company of Canada will use the information in this form to determine your patient's eligibility for disability benefits.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that this information, including any medical records submitted in support of this claim, will be treated confidentially.

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to your patient and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of your patient or in harm to a third party.

History

1. What was the date of the patient's first appointment for the claimed disability? Date (dd-mm-yyyy): – –
2. What was the date of the patient's latest appointment? Date (dd-mm-yyyy): – –
3. How often are the patient's appointments? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other Please specify:
4. Did you recommend that the patient stop work? ☐ No ☐ Yes If yes, as of what date? Date (dd-mm-yyyy): – –
5. Was the patient's disability caused by an accident? ☐ No ☐ Yes If yes, give details and the date of the accident.
6. Describe the pertinent symptoms, their severity, their duration and their impact on the claimed disability (including the patient's ability to work).
7. When did the symptoms first appear? Date (dd-mm-yyyy): – –

Return to Introductory Page

History (continued)

8. Has the patient ever had a similar or related condition? ☐ No ☐ Yes If yes, state when and describe the condition.

9. Is the condition due to injury or illness caused by employment? ☐ Unknown ☐ No ☐ Yes If yes, give details.

10. Is the condition due to or related to pregnancy? ☐ No ☐ Yes If yes, give date of confinement.

Date (dd-mm-yyyy)

11. In relation to the patient's job responsibilities and duties, how is the patient restricted or limited by the condition?

Clinical findings

Please describe the physical findings in relation to the claimed disability.

Diagnoses

What are the diagnoses that have led to the disability claim? Please list them in order of their impact on the patient's disability. If the condition is psychiatric, use DSM IV terminolgy.

Documents required (as applicable)
Copies of all

- investigation reports
- laboratory data
- consultation reports
- hospital admission histories and discharge summaries

Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the disability being claimed.

Treatment

1. Was the patient hospitalized? ☐ No ☐ Yes If yes, give dates.

From Date (dd-mm-yyyy) To Date (dd-mm-yyyy)

Return to Introductory Page

Treatment (continued)

2. Was surgery performed? ☐ No ☐ Yes If yes, give details.

Date (dd-mm-yyyy)	Type of Surgery
_ _	
_ _	
_ _	

3. What medications were given to the patient? Please include name(s), dosage(s) and the dates of any medication changes.

4. Was psychotherapy given? ☐ No ☐ Yes If yes, give frequency and duration.

5. Was physiotherapy/chiropractic treatment given? ☐ No ☐ Yes If yes, give frequency and duration.

6. What other treatments were given?

7. Please give the names, specialties and appointment dates of all other treating physicians.

Last name	First name
Specialty	Appointment date (dd-mm-yyyy) _ _
Last name	First name
Specialty	Appointment date (dd-mm-yyyy) _ _
Last name	First name
Specialty	Appointment date (dd-mm-yyyy) _ _
Last name	First name
Specialty	Appointment date (dd-mm-yyyy) _ _

Cardiac (Complete if applicable)

1. What is the functional capacity (American Heart Association)? If class 3 or 4, please include a copy of any stress tests or cardiac echograms.
   ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
   ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

2. What is the latest blood pressure reading for the patient? /

Return to work plan

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?
   ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

2. What is the patient's current status?
   ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

Return to Introductory Page

Return to work plan (continued)

3. Can the patient return to part-time or modified work? ☐ No ☐ Yes If yes, please give details about the return-to-work plans for the patient including dates for each step of the plan and expected date of return to work. Please describe any limitations or restrictions in work duties.

4. Is the patient fit for any other occupation? ☐ No ☐ Yes If yes, please give details about the return-to-work plans for the patient including dates for each step of the plan and expected date of return to work. Please describe any limitations or restrictions in work duties.

5. Please describe any factors not mentioned above that may affect this patient's ability to return to work, (such as social pressure, stress in the workplace or abuse of medication, alcohol or any other substance).

Cooperation and willingness to return to work

1. Please comment on how cooperative the patient has been with the treatment plan.

2. Please comment on the patient's willingness to work.

Additional information

1. In your opinion, is the patient capable of handling his/her own financial affairs? ☐ No ☐ Yes
2. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Medical Consultant? ☐ No ☐ Yes
3. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Rehabilitation Specialist? ☐ No ☐ Yes

Physician's information

First name	Last name	
Address (street number and name)		
City	Province	Postal code
Telephone number	Fax number	Specialty

Physician's signature

Signature	Date (dd-mm-yyyy)
X	

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Assurance Company of Canada Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

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

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

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

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

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