Long-Term Disability
SunAdvantage
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	• Print the completed Plan Sponsor's Statement (pages 2 - 8) and sign the Declaration at the end of the form. • Fax the form to the Sun Life 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.

Plan Sponsor's Statement for Long-Term Disability Benefits

Life's brighter under the sun

Sun Life Financial

Plan Sponsor's Statement
Claim for Long-Term Disability benefits
SunAdvantage

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.

Part 1: Employment and coverage information

1 Plan Member information

Sun Life Assurance Company of Canada must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety and submit it at least 8 weeks before the end of the elimination period in order to avoid delays.

First name	Last name (Quebec residents – maiden 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

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

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)
– –	– –	– –

Was the member's employment terminated? ☐ No ☐ Yes If yes, on what date? Date (dd-mm-yyyy) – –

To the best of your knowledge, why did the member stop working?

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

Effective date of member's basic LTD coverage with Sun Life Assurance Company of Canada (dd-mm-yyyy)	Effective date of optional LTD coverage with Sun Life Assurance Company of Canada (if any) (dd-mm-yyyy)
Coverage class (if any)	Was the member required to submit evidence of insurability? ☐ No ☐ Yes

1. Has LTD coverage ended? ☐ No ☐ Yes If yes, when? Date (dd-mm-yyyy)

2. Have LTD premiums ended? ☐ No ☐ Yes If yes, when? Date (dd-mm-yyyy)

Please complete in reference to Group Life coverage

Is the member presently insured for Group Life coverage that provides for "Waiver of Premium" while on disability under any Sun Life Assurance Company of Canada group contract? ☐ No ☐ Yes **If yes, return copies of all enrolment cards and/or enrolment forms that the member has signed for any Life benefits.**

Contract number Effective date Date (dd-mm-yyyy)

Type of Group Life coverage

☐ Basic Life $	☐ Optional Life $	☐ AD&D $
☐ Optional AD&D $	☐ Dependent Life $	☐ Dependent Optional AD&D $
☐ Dependent Optional Life $		

5 Earnings and benefit information

If the plan member is tax exempt, and the benefit is taxable, please provide a copy of the documentation supporting their tax exempt status.

Gross monthly earnings as of last day worked (exclude overtime, commissions and bonuses) $	Less Federal/Provincial income tax $
Average monthly commissions earned in the last 24 months. $	If applicable, please provide a copy of the tax information slips issued for the past two years for this commissioned member.

Total personal income tax exemptions according to the last TD1 form (Federal) $	Total personal income tax exemptions according to the last TP-1015-3V form (Quebec residents only) $	Social Insurance Number

5 Earnings and benefit information (continued)

1. Is the plan under which this member is covered taxable? ☐ No ☐ Yes
   If yes, please provide the Social Insurance Number above for the member as it is required for the issuance of the applicable tax information slip(s).
2. Did the member have any scheduled vacation days after the last day worked? ☐ No ☐ Yes
   If yes, how many days? _____
3. Does the member have unused sick leave? ☐ No ☐ Yes If yes, how many days? _____
4. Last day member's salary was paid (or will be paid)? Date (dd-mm-yyyy) – –
5. Does the member currently receive remuneration from you? ☐ No ☐ Yes If yes, answer a) and b) below.
   a) How much? $ per month Does this amount include unused sick leave? ☐ No ☐ Yes
   b) Until what date will remuneration continue (including sick leave credits)? Date (dd-mm-yyyy) – –
6. According to your records, what is the LTD benefit amount? $ per month
7. Are modified duties available? ☐ No ☐ Yes
   Were modified duties offered? ☐ No ☐ Yes If yes, please describe duties (part-time/full-time/modified).

   Did the member accept modified duties if offered? ☐ Yes ☐ No If no, please provide details below.
8. Does the member belong to a retirement or superannuation plan?
   ☐ No ☐ Yes If yes, Registration no.
9. What amount, if any, will the member receive under your retirement or pension plan? $
10. To your knowledge, has the member applied for benefits from CPP, QPP or any other government sponsored plan? ☐ No ☐ Yes
11. Is the member eligible for early retirement pension? ☐ No ☐ Yes If yes, give details below.
    ☐ **reduced** On what date? Date (dd-mm-yyyy) – – Has the member applied? ☐ No ☐ Yes
    ☐ **unreduced** On what date? Date (dd-mm-yyyy) – – Has the member applied? ☐ No ☐ Yes

6 Workers' Compensation

1. If the member's illness or injury is work related, have they applied for Workers' Compensation benefits?
   ☐ No ☐ Yes If yes, please continue.

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

2. Has the member received a permanent disability award?

   ☐ No ☐ Yes If yes, when did they 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? $ _____

3. If the member's claim has been denied or terminated, have they appealed the decision?

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

   Please indicate the stage of the member's appeal (if known).

   ☐ Oral ☐ Board of review ☐ Medical panel ☐ Medical review

   ☐ Other _____

7 Declaration for Part 1

I certify that the statements in Part 1 of this form are true and complete.

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

Part 2: Information about the member's disability and job

1 Plan Member information

First name	Last name (Quebec residents – maiden name)	Member ID

2 Information about the disability and rehabilitation

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. From your observations did the member's ability to perform his or her job change?

2. When did the member's illness or injury first appear to affect his or her work? Date (dd-mm-yyyy) – –

3. Were any changes made in the member's job as a result of the illness or injury?
   ☐ No ☐ Yes If yes, give details.

What were the changes and when were they made?

4. If the member could return to work part-time or with a change in duties, would a position be available?
   ☐ No ☐ Yes If yes, give details.

3 Recent job history

1. On the last day worked, what was the member's:

Job Title	Occupation

2. How long has the member worked in this position?

Years	Months

3. If the member changed occupations or assignments during the 12 months immediately before the last day worked, describe the previous occupation or assignment, give reason for the change and the effective date of the change.

4. Please give dates and details of any sick leave, maternity leave or lay-off during the 12 months before the disability began.

Type of leave	Details	Beginning date (dd-mm-yyyy)	End date (dd-mm-yyyy)
		– –	– –
		– –	– –
		– –	– –

4 Work environment and job activities

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

3. During the 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 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 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 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	☐	☐	☐	☐

4 Work environment and job activities (continued)

7. Please list any machines, tools, or other equipment that the 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	No. of times per day OR Percentage of time

8. Cognitive/non-physical aspects of the job

Does the member have to answer complaints? ☐ No ☐ Yes

Is the member primarily evaluated on production? ☐ No ☐ Yes

Does the member work closely with co-workers? ☐ No ☐ Yes

Is the member responsible for the performance objectives/ decision making within his/her particular department? ☐ No ☐ Yes

Number of people this member supervises:

What percentage of the 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.

5 Additional remarks

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

6 Declaration for Part 2

I certify that the statements in Part 2 of this form are true and complete.

Last name of person signing this statement (please print)	First name	Position

Authorized signature	Date (dd-mm-yyyy)
X	– –

Telephone number	Fax number
– –	– –

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

To ensure prompt submission, please fax this form, along with any other information in support of the plan member's claim, 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 live in the Atlantic provinces, Quebec or Ottawa

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

For all other provinces or territories

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