Short-Term Disability
Plan Member Package

How to use this package:

REVIEW	• The links below will take you to the Short-Term Disability (STD) 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 STD 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 - 13) and sign the Authorization. • Print the Attending Physician's Statement (pages 14 - 15) 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 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.

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

Life's brighter under the sun

Sun Life Financial

Short-Term Disability
Claim Guide

Life's brighter under the sun

Short-term disability benefits are provided by Sun Life Assurance Company of Canada.

Sun Life Financial

Short-Term Disability (STD) 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 Short-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.

Reporting your absence

To apply for STD benefits, you and your employer will need to send us a completed STD 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.
- 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 STD 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 as soon as possible after the beginning of your absence, as most contracts limit the period of time in which to submit a claim.
- 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 may also contact you to conduct a telephone interview to ask some further questions. 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 5 business days after we receive all the necessary information. If we determine that your claim is approved according to your employer's STD 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. 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 to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's statement, or as permitted or required by law.

FAQs

We want you to feel comfortable with the Short-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.

How are my benefits calculated?

Disability benefit payments are usually based on a specific percentage of your weekly 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?

STD benefits are paid on a weekly 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 STD, you will continue to receive disability payments as long as you meet the definition of total disability. Usually, this means you are 'totally disabled' for your own occupation up to the maximum benefit period. The definition of total disability and the maximum benefit period for your plan are defined in your employee benefits booklet.

There are also other requirements you must meet in order to continue to receive disability payments. These include continuing to explore new employment opportunities, pursuing appropriate treatment or attempting modified work duties.

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

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.

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 STD 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 medication, diagnosis and treatment information obtained by Sun Life concerning your health is strictly confidential and not shared with anyone at your employer unless specifically outlined in the authorization you have signed on your Plan Member's Statement.

We do not share medication, diagnosis and treatment information with your manager or Human Resources department at work.

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.

What happens if I'm unable to return to work before the maximum benefit period?

If your absence is anticipated to extend beyond the maximum benefit period provided under your employer's STD plan, and you have LTD coverage with us, we will forward to you a Disability Transition form 8 weeks prior to the end of the STD benefit period. This form is required in order to address specific coverage information required in the assessment of your LTD claim. We will also forward a similar form to your employer to complete at that time. We usually do not need another Attending Physician's Statement completed as we rely on the medical information gathered during the management of your STD claim.

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

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Sun Life Financial

Plan Member's Statement
Claim for Short-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

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 Short-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)

Address (street number and name)	Apartment or suite

City	Province	Postal code

Occupation	Job title	Social Insurance Number

Home telephone number	Alternate telephone number	Email address

2 Plan Sponsor information

Contract number	Member ID	Division/Billing group number

Company name

Address (street number and name)

City	Province	Postal code

Contact person	Contact's telephone number	Ext.

3 About your illness or injury

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.

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

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

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

3 About your illness or injury (continued)

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.)

When was your last day of full-time duties/hours? Date (dd-mm-yyyy) – –

When was your last day of modified work (if applicable)? Date (dd-mm-yyyy) – –

What is the date you returned or expect to return to work? Date (dd-mm-yyyy) – –

During this period, have you worked at any occupation or employment? ☐ No ☐ Yes If yes, please explain.

What are the current symptoms preventing you from working?

Is your condition related to pregnancy?
☐ No ☐ Yes If yes, what is your delivery date? Date (dd-mm-yyyy) – –

Please describe your complications, if any.

4 Disability as a result of an accident

1. Is your disability the result of an accident?
   ☐ No If no, continue with the next section "**Your other income**".
   ☐ 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? ☐ Yes ☐ No 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 – –

4 Disability as a result of an accident (continued)

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.

5 Your other income

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

6 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.

7 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 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	Date (dd-mm-yyyy)
X	– –

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 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

8 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
Short-Term Disability Claim

Sun Life Financial

Purpose of Statement This Statement is to assist Sun Life Assurance Company of Canada in making a decision on your patient's claim for disability benefits.

Return address 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:	Toronto:	Halifax:	Montreal:	Kitchener - Waterloo:	Vancouver:
Fax: 1-866-639-7820	**Fax: 1-866-639-7851**	**Fax: 1-866-639-7850**	**Fax: 1-866-639-7846**	**Fax: 1-866-209-7215**	**Fax: 1-866-639-7829**
PO Box 2733 Stn Main	PO Box 950 Stn A	PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Montreal QC H3C 5P5	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6

1 Plan Member information and authorization to be completed by patient

Last name (Quebec residents – maiden name)	First name	Home telephone number	Alternate telephone number
		– –	– –

Address (street number and name)	Apartment or suite

City	Province	Postal code

Plan Sponsor name	Contract number	Member ID number

Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)
		– –	– –	– –

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	Date (dd-mm-yyyy)
X	– –

2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Page 1 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.

Diagnosis

Primary:

Secondary:

If childbirth: expected or actual delivery date (dd-mm-yyyy) – – ☐ Vaginal ☐ C-Section

Occupational illness/injury Is condition arising from employment? ☐ Yes ☐ No

Start dates of current work absence

Date of first visit during current period of absence (dd-mm-yyyy) – –

First date of work absence due to condition (dd-mm-yyyy) – –

Hospitalization

Has your patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy) – –

Have they had day surgery? ☐ Yes ☐ No Date discharged (dd-mm-yyyy) – –

Name of institution:

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy) – – Description Type of anaesthetic

Treatment (Drug, dosage, physiotherapy, other)

Prognosis – Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) – –

Visits – Frequency of visits ☐ Weekly ☐ Monthly ☐ Other

Symptoms – Describe current symptoms, severity and frequency.

Investigations – **Please attach copies of all relevant:**

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Are tests/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy) – –

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist Specialty Date of visit (dd-mm-yyyy) – –

Restrictions and limitations – Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

4 Attending Physician's acknowledgement

I acknowledge that the information in this Statement will be kept in a group disability benefits file with Sun Life Assurance Company of Canada and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address			
Telephone number – –	Fax number – –		
Physician's signature X		Date signed (dd-mm-yyyy) – –	

NOTE: The patient is responsible for any charge made for the completion of this form.

Canadian Life and Health Insurance Association Inc. Association canadienne des compagnies d'assurances de personnes inc.