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 this 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	E-mail 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

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) – –

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)
			– –
			– –
			– –

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.

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
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

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.

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 on-line 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 a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

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 name (please print)	
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 e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.