

# Plan Member's Statement Claim for Long-Term Disability Benefits



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

## 1 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 the member's responsibility.**

If the Plan Sponsor pays any portion of the premium, the plan is taxable. Your Social Insurance Number is required for T4As.

Contract Number		Member ID	Date of Birth (d/m/y)	
Name - first and last name (Quebec residents - maiden name)				<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (street number and name, apartment or suite)				
City		Province	Postal Code	
Occupation	Job Title	Social Insurance Number		Daytime Telephone Number (    )

## 2 Plan Sponsor information

Company Name		Division Number
Street Address		
City	Province	Postal Code
Contact Person	Contact's Telephone Number (    )	Ext.

## 3 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 void cheque** or for a savings account, please provide the following account details. Please check with your Benefits Administrator to determine if this option is available to you.

Bank Name		
Address		
Bank Number □ □ □	Branch Number □ □ □ □ □	Account Number □ □ □ □ □ □ □

## 4 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.)


Date (d/m/y)

2. When did your symptoms first appear?

3. Have you ever had the same or similar illness or injury? No  Yes  Please explain and give dates

Empty text box for explanation and dates.

Date (d/m/y)

4. On what date did you first see a doctor for this illness?

Date (d/m/y)

5. From what date did your illness or injury prevent you from working?

6. Is your illness or injury work related? No  Yes  Please explain

Empty text box for explanation.

7. Did the doctor recommend a change in your daily habits or restrictions on the type of work you could do? No  Yes  Please describe the change and the date the change was made.

Empty text box for description of change.

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

Empty text box for list of treatments.

9. 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 (d/m/y)

10. When do you expect to be able to return to your own job?

Date (d/m/y)

Full-time   
Part-time

11. When do you expect to be able to do any other job?

Date (d/m/y)

Full-time   
Part-time

12. Have you tried to return to work already? No  Yes  Please answer the following questions.

What were the dates that you returned to work? From

Date (d/m/y)

to

Date (d/m/y)

Did you return to:  your own job  new job or modified duties  
Did you return to:  full-time  part-time

## 5 Disability as a result of an accident

1. Is your disability the result of an accident?

No  ► Continue with the next section "Your general medical history."

Yes  ► What was the date, time and location of the accident?

Date	Time	Location
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2. If your disability is the result of an accident, are you taking legal action against any other person or organization?

No  ► Explain why you are not taking legal action.


Yes  ► Please complete the following:

Name of Lawyer		
Address		Telephone (     )
City	Province	Postal Code

On what date did the legal action start?

Date (d/m/y)

Has a settlement been reached? No  Yes  ► Please attach a copy of the terms of the settlement.

## 6 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	Dates of Stay (d/m/y)

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

Doctor	Address	Nature of Illness	Dates of Visit (d/m/y)

## 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?

Yes  ► When did you apply?

Date (d/m/y)

No  ► Give reasons why you have not applied.


2. If you have applied for a Disability Pension, has your application been approved?

Yes  Please include a copy of the Notice of Entitlement with this form.

Benefit effective date:  Benefit amount per month? \$

No  Please explain and provide a copy of the denial letter. (For example, if you have been denied or you are appealing a decision, please explain and give dates.)


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

Full Name	Relationship to you		Date of Birth			If child is 18 or over check whether child is:	
	Son	Daughter	Day	Month	Year	Handicapped	Full-time Student
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

**8 Workers' Compensation**

1. If your illness or injury is work related, have you applied for Workers' Compensation benefits?

Yes  No  Please explain.

2. Are you receiving, or do you expect to receive, Workers' Compensation benefits? No  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  When did you receive it?

Was it a monthly benefit? No  Yes  What was the amount? \$

Was it a lump sum settlement? No  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?

Please indicate the stage of your appeal (if known)?

- Oral                       Boards of review                       Medical panel  
 Medical Review                       Other \_\_\_\_\_

## 9 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 <input type="checkbox"/> Week <input type="checkbox"/> Month
	Yes	No		Yes	No	Current	Expected	
Any other disability insurance (ie. Union Disability Benefit, Creditor, Credit Cards, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auto insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Group/Association/ Individual Plans	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment Insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employer Disability or Retirement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Criminal Victims Benefit	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Severance or Retirement Package	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## 10 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 Rehabilitation Specialist.

1. What has your doctor told you about returning to work?


2. Have you discussed returning to work with your employer, either to your own job with or without a change in duties or to another position? No  Yes  If yes, please give details.


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.


## 11 Your education and acquired skills

1. What was the highest grade level you completed or the highest degree you obtained?

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2. 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.


3. Do you have a valid driver's licence? No  Yes  Class

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


## 12 Your work experience

Attach a resume if available.

From	To	Employer	Job Title and Duties

## 13 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan. As Administrator of this plan, we may 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 licence 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 may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event that this Plan is audited.

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.

I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to exchange information about me, **except** for details relating to diagnosis, treatment or medication, that is relevant to this claim for the purpose of planning and managing my rehabilitation and return to work.

Name (please print)	
Member's signature X	Date (d/m/y)

**After you have completed this form, insert in the "Private and Confidential" envelope provided, seal and send directly to the Sun Life Assurance Company of Canada Group Disability Management office that is managing your claim. If you are not sure which office to send your information to, please contact your Benefits Administrator. If you prefer you may give the sealed envelope to your employer or fax the form directly to the appropriate office.**

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