

Plan Member's Statement Disability Transition Form

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 Statement 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	
Home Telephone Number ()		Social Insurance 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 Waiver of Premium

Do you have Life insurance coverage with a Waiver of Premium provision? Yes No If yes, please ensure your Plan Sponsor returns copies of all enrolment cards.

6 Canada/Quebec Pension Plan Benefits (continued)

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"/>

7 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 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. WCB/WSIB/CSST, 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"/>	

8 Your education and acquired skills

1. What was the highest grade level you completed or the highest degree you obtained? Attach a resumé, if available.

--

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.

9 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefits plan. As Administrator of this plan, we may check 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.

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 agree that Sun Life Assurance Company of Canada and my Plan Sponsor may share financial information related to my claim for purposes relevant to the management of the plan. 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 fax the form directly to the appropriate office or give the sealed envelope to your employer to send to us.

Visit our Web site:
[www.sunlife.ca/
health and work](http://www.sunlife.ca/health-and-work)

Halifax:
Fax: 1 866 639-7850
1100 - 1809 Barrington Street
Halifax NS B3J 3K8

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

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

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

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