

# Sun Life Assurance Company of Canada

## Life Benefits Claim Packet



### Use this claim packet for:

- Waiver of Premium Benefits – totally disabled without further premium payments
- Accelerated Benefits – terminal illnesses
- Accidental Dismemberment Benefits – accidental bodily injury or loss
- Permanent Total Disability Benefits – permanently and totally disabled

Do not use this claim packet for Death claims. Instead use the Sun Life Assurance Company of Canada Death Claim Packet (XGR/2361).

### Instructions for the Plan Administrator

In the event of an illness, dismemberment or disability of an insured, please follow these steps as soon as you determine that the insured is eligible for Accelerated Benefits, Waiver of Premium Benefits, Permanent Total Disability Benefits and/or Accidental Dismemberment Benefits.

1. Complete the Employer's section of this claim packet and collect the following:
  - a copy of any and all enrollment forms
  - a copy of the most recent beneficiary designation on file
  - a copy of payroll records for at least the last two pay periods prior to the date of disability
2. The claimant completes the Claimant's Statement and Authorizations and collects the following:
  - a copy of all medical records from date of disability/loss to present
3. The physician completes the Attending Physician Statement section
4. **The employee collects all completed sections and additional required information and submits the entire packet to:**

Sun Life Assurance Company of Canada  
Group Life Claims, SC 4375  
One Sun Life Executive Park  
P.O. Box 81100  
Wellesley Hills, MA 02481  
Tel: 1-800-247-6875  
Fax: 1-888-551-2084

**Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment, or approval of Waiver of Premium.**

State law requires that we notify you of the following:

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Fraud Warning – AR, DC, KY, LA, MA, MN, NM, TX and WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Warning - AK:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Fraud Warning - AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Fraud Warning - CA:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Fraud Warning - CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Fraud Warning - FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Fraud Warning - IN, ID, and DE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Fraud Warning – MD:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Fraud Warning - ME, TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

**Fraud Warning - NH:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

## Fraud Warnings continued

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**Fraud Warning – NJ:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Fraud Warning - OH:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Fraud Warning – OK:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Fraud Warning – OR:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Fraud Warning – PA:** Any person who knowingly and with intent to defraud any insurance company or any other person files a claim for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Fraud Warning – VT:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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# Sun Life Assurance Company of Canada

## Life Benefits Claim Packet



### Section A: Employer's Statement

#### 1 General Information

Type of Claim:     Waiver of Premium Benefits                       Accidental Dismemberment Benefits  
                                   Accelerated Benefits     Permanent Total Disability Benefits

Please print clearly.

Employer's name		Group policy number	Class
Employer contact (name of person completing this form)		Title	
Employer's street address		City	State    Zip code
Employer's email address		Telephone number	Fax number
Name and address of Division where employee works			

#### 2 Employee Information

Employee's name (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)
Employee's home address	City	State	Zip code

#### 3 Dependent Information

**Complete only if submitting a Dependent claim.**

Dependent's name (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (m/d/y)	Relationship to employee
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#### 4 Employment and Claim Information

Basic insurance amount \$	Optional insurance amount \$	Number of regular hours worked	
Date of disability or loss (m/d/y)		Date hired (m/d/y)	Effective date of insurance
Why did employee cease working? <input type="checkbox"/> Illness <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Layoff <input type="checkbox"/> Retired	<input type="checkbox"/> Still working <input type="checkbox"/> Date last worked: _____		Occupation

## 5 Salary and Benefits Information

How was the employee paid? (check one)

<input type="checkbox"/> Hourly \$ per hour:	<input type="checkbox"/> Salaried \$ per year:
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Provide information about other income:

Commissions \$	Bonuses \$	Overtime \$
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What was the date of the last pay increase?

Please attach the following and submit with the completed Employer's Statement:

- All enrollment and beneficiary forms.
- Documentation of the employee's current class and benefit.
- Payroll records for at least the last two pay periods prior to the date of disability.

## 6 Certification and Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warnings on pages 2 and 3 of this packet.

Signature of Plan Administrator X	Date signed
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# Sun Life Assurance Company of Canada

## Life Benefits Claim Packet



### Section B: Claimant's Statement

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

#### 1 General Information

Please print clearly.

Employee's name (first, middle initial, last)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)	
Employee's home address			City	State	Zip code
<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Occupation		Telephone number	
Employer's name				Group policy number	

#### 2 Information About the Disability/Loss

**\*You may elect to receive up to 75% of your Group Life insurance benefit once during your lifetime, subject to your plan maximum. Benefits may vary by state and by contract.**

What was the date of your accident or when you first noticed symptoms of your illness (m/d/y)	
Describe how, when and where the accident occurred or the nature of your illness and its first symptoms.	
<b>For Accidental Dismemberment Only</b> - Please state the date and nature of your loss.	
<b>For Accelerated Benefits Only</b> - Write in the amount you are requesting.*	
Date you were first treated by a physician	Date last worked prior to disability
Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, give date	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No

#### 3 Information About Physicians and Hospitals

Please provide the names and addresses of all physicians you have seen for this condition.

If you need more space, attach additional pages.

Physician's name		Physician phone number	
Address			
Specialty		Date of treatment	
Physician's name		Physician phone number	
Address			
Specialty		Date of treatment	

**3 Information About Physicians and Hospitals** *(continued)*

Please provide this information if you have been hospital-confined for this condition.

Name of hospital	Date of confinement
Address	

If you need more space, attach additional pages.

Name of hospital	Date of confinement
Address	

**4 Information About Your Training, Education and Experience**

Complete this section if this is a Waiver of Premium claim.

What is your level of education?

Grade School    High School    Trade School    College

Other Course (please specify) \_\_\_\_\_

Please attach a copy of your resume, if applicable.

List all previous occupations and the dates worked for each employer.

Employer's Name	Dates of Employment	Occupation/Type of Work

**5 Information About Social Security Disability Benefits**

Have you applied for Social Security .....  Yes    No

If "Yes," what is the status of your application?

Pending    Approved    Denied    Other: \_\_\_\_\_

**6 Signature**

**Reminder:** Please be sure to sign and return any Authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 2 and 3 of this claim packet.

Employee's signature X	Date signed
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# Sun Life Assurance Company of Canada

## Life Benefits Claim Packet



### Section C: Authorization

#### Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:  
 Sun Life Assurance  
 Company of Canada  
 One Sun Life Executive  
 Park, SC 4375  
 P.O. Box 81100  
 Wellesley Hills, MA 02481  
 Fax: 1-888-551-2084

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”) its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims Department, Sun Life Assurance Company of Canada, SC 4375, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

## Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:  
 Sun Life Assurance  
 Company of Canada  
 One Sun Life Executive  
 Park, SC 4375  
 P.O. Box 81100  
 Wellesley Hills, MA 02481  
 Fax: 1-888-551-2084

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”) its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that the Company will use the information it obtains to: (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims Department, Sun Life Assurance Company of Canada, SC 4375, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

## Authorization for Release and Disclosure of Non-Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:  
 Sun Life Assurance  
 Company of Canada  
 One Sun Life Executive  
 Park, SC 4375  
 P.O. Box 81100  
 Wellesley Hills, MA 02481  
 Fax: 1-888-551-2084

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., Social Security Administration, Internal Revenue Service or the Veteran's Administration, to disclose to Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators, and reinsurers, any and all non-health information relating to me, including, but not limited to, (a) my employment earnings; (b) my occupational duties; (c) my credit history, (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I, or my dependents, may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage, (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize the Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim. I further authorize The Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

I understand that The Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law. This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims Department, Sun Life Assurance Company of Canada, SC 4375, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

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**Section D: Attending Physician's Statement – Physical conditions only**

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

**1 Information About the Patient**

The patient is responsible for any costs associated with the completion of this form.

Please print clearly

Name of patient (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)	
Patient's home address	City	State	Zip code	
Name of employer	Group policy number		Employee phone no.	

Do you believe this patient is competent to endorse checks?.....  Yes....  No

**2 Diagnosis and History**

Provide general information about diagnosis, treatment, doctor's notes and history in this section.

Diagnosis including any complications and ICD-9 Codes(s)	
<b>For Accelerated Benefits Only - If the patient has a terminal illness, please indicate the life expectancy:</b> _____ Months <input type="checkbox"/> N/A	
Include objective findings (i.e., x-rays, EKGs, MRIs, laboratory data and any other clinical findings) <input type="checkbox"/> N/A	
Subjective findings <input type="checkbox"/> N/A	
Date symptoms first appeared or accident occurred (m/d/y) <input type="checkbox"/> N/A	Date disability commenced (m/d/y) <input type="checkbox"/> N/A
If injury due to a motor vehicle accident, indicate which state the accident occurred.	
Patient's height:	Patient's weight:
Blood pressure:	
Is condition due to injury/sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Names and addresses of other treating physicians (if applicable)	
If pregnancy, please provide the following information: Expected delivery date: _____ Actual delivery date: _____ C-Section?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe any complications that would extend this disability longer than a normal pregnancy.	

### 3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit <input type="checkbox"/> N/A	Date of last visit <input type="checkbox"/> N/A	Date of last examination <input type="checkbox"/> N/A
Frequency of treatment ..... <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (please specify: _____)		
Description of Treatment		

### 4 Progress

Patient's progress: .....  Unchanged  Retrogressed  Improved  Recovered  
 Is patient: .....  Ambulatory  Bed confined  House confined  Hospital confined

If unchanged or retrogressed, please explain:		
If patient has been hospital confined, give dates.	From:	To:
Provide name and address of hospital (if applicable)		

### 5 Limitations

Please note that additional occupational information may be required.

Patient may use hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient may use feet for repetitive movement as in operating foot controls .....  Yes  No

During the day, is the patient able to:

	67-100%	34-66%	1-33%	0%
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient capable of working within these restrictions/limitations? .....  Yes  No

Can the employee work an 8 hour day with the above restrictions? .....  Yes  No

If not, how many hours could they work with the above restrictions? \_\_\_\_\_

## 6 Physical Impairment

- No limitation of functional capacity; capable of heavy work\*.....No Restrictions (0 - 10%)
- Medium manual activity\* ..... (15 - 30%)
- Slight limitation of functional capacity; capable of light work\* ..... (35 - 55%)
- Moderate limitation of functional capacity; capable of clerical/administrative (sedentary\*) activity..... (60 - 70%)
- Severe limitation of functional capacity; incapable of minimum (sedentary\*) activity .....(75 - 100%)

\* As defined in Federal Dictionary of Occupational Titles.

## 7 Cardiac (if applicable)

Functional Capacity (American Heart Association)

- No limitation     Slight limitation     Marked limitation     Complete limitation

Therapeutic Class (activity)

- No restriction     Slight restriction     Marked restriction     Complete restriction

Blood Pressure - Last Visit \_\_\_\_\_

## 8 Work Capabilities

Is patient capable of working within these limitations?.....  Full time     Part time

Is patient capable of another occupation on a full-time basis? .....  Yes     No

Is patient capable of another occupation on a part-time basis?.....  Yes     No

## 9 Prognosis

How long will those limitations apply? (estimate)

- 6 weeks     8 weeks     12 weeks     Longer

## 10 Certification and Signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on pages 2 and 3 of this packet.

Name of attending physician		Degree/Specialty	
Street address		City	State    Zip code
Tax ID number		Telephone number	Fax number
Signature of attending physician X			Date

# Sun Life Assurance Company of Canada

## Life Benefits Claim Packet



### Section E: Attending Physician's Statement – Behavioral health conditions only

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

#### 1 Patient Information

The patient is responsible for any costs associated with the completion of this form.

Please print clearly

Name of Patient (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)
Do you believe this patient is competent to endorse checks? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No

- Patient is able to function under stress and engage in interpersonal relations (no limitation)
- Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
- Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
- Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
- Patient has significant loss of psychological, physiological, personal and social adjustments (severe limitation)

In order to evaluate a claim for Disability Benefits submitted by your patient, we need more detailed information about his/her medical condition. Please respond to the following questions. Thank you.

Axis I	_____	DSM IV TR Code	_____
Axis II	_____	DSM IV TR Code	_____
Axis III	_____	No Code	_____
Axis IV	_____	No Code	_____
Axis V	_____		

GAF: Current:	Baseline:	Highest in past year:
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#### 2 Treatment Information

When did the patient first experience psychiatric symptoms?
What was the first date you treated the patient for symptoms?
Name of first treating physician for symptoms (first, middle initial, last)
Please list facilities and dates of any hospitalization, intensive outpatient program, or partial hospitalization program.
What was the diagnosis at that time?

## 2 Treatment Information continued

Current diagnosis
Describe the patient's current psychiatric symptoms and mental status evaluation.
Is the patient's current condition related to chemical dependency? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe
Has there been any psychological testing? If available, provide results.  If not, why?  Are there any plans in the future to perform testing?
Current treatment methods/treatment plan, please describe.
List medications with dosages. Please note any recent changes.
Please describe patient's response to treatment to date. (Include any past treatments and additional methods of treatment being considered.)
Please describe if the patient's psychiatric condition is limiting the patient's functional capacity.

## 3 Prognosis

How long will those limitations apply? (estimated)

6 weeks       8 weeks       12 weeks       Longer

## 4 Certification and Signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on pages 2 and 3 of this packet.

Name of attending physician		Degree/Specialty	
Street address		City	State    Zip code
Tax ID number	Telephone number	Fax number	
Signature of attending physician X			Date

## **PRIVACY INFORMATION NOTICE**

This notice explains why Sun Life Assurance Company of Canada (“the Company”) collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

### **COLLECTION OF INFORMATION**

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, health care providers, medical professionals, hospitals, clinics or other medical or health care related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

### **DISCLOSURE OF PERSONAL INFORMATION**

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

### **ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION**

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Assurance Company of Canada  
Group Life Claims, SC 4375  
One Sun Life Executive Park  
P.O. Box 81100  
Wellesley Hills, MA 02481