Plan Member's Statement
Claim for Disability benefits

Sun Life Assurance Company of Canada, a member of the Sun Life 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 Short-Term Disability (STD) and where applicable, Long-Term Disability (LTD) 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 or if applicable, Long-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	☐ 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		
What province were you living in at the time your coverage became effective under this plan?	Preferred language of correspondence ☐ English ☐ French		

If you would like Sun Life to email you, please fill in your email address below. Sun Life will write to you through secure email.

Email address

2 Plan Sponsor information

Contract number	Member ID	Company name
Contact person	Contact person email	Contact person phone number

3 About your illness or injury

You must notify Sun Life 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.

1. Please describe your present illness or injury and how it occurred.

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

3 About your illness or injury (continued)

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

4. 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.

5. From what date did your illness or injury prevent you from working? Date (dd-mm-yyyy)

6. Please include a list of the duties of your job that you are unable to do.

7. What treatments are you presently receiving (Medications, physiotherapy, psychotherapy, 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)**

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

9. When do you expect to be able to return to work? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

10. 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 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? ☐ No ☐ Yes 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.

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	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	When are your benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. WCB/WSIB/ CNESST, 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 permission

Please fill out and sign:

- the Plan Member's Disability Statement (this form)
- section 1 of the Attending Physician's Statement.

I agree that the statements in this form are true and complete.

Reference to Sun Life or the plan sponsor includes their agents and service providers.

I allow Sun Life and its re-insurers to collect, use and disclose:

- information needed to process my STD claim or my LTD claim
- relevant information with health professionals, institutions, investigative agencies, insurers and, where appropriate, my plan sponsor to underwrite, administer and adjudicate my claims.

I allow Sun Life and my plan sponsor to collect, use and disclose:

- financial information related to my claim needed for Plan administration
- relevant claims information – except for details about my diagnosis and treatment.

Sun Life and my plan sponsor will disclose relevant claims information for managing my accommodation, vocational rehabilitation and return to work.

Occupational health services

If my plan sponsor has an occupational health services team:

- Sun Life and the occupational health services team can collect, use and disclose information to manage my accommodation, vocational rehabilitation and return to work. This includes information about my diagnosis and treatment.

Overpayment

If Sun Life overpays me, I allow them to:

- recover the money from any amount payable to me under my benefit plan(s)
- collect, use and disclose my information with others, including collection agencies and my plan sponsor, to recover the money.

Preventing fraud and Plan abuse

If Sun Life suspects fraud or Plan abuse, Sun Life can investigate my claim. To detect, investigate and prevent fraud and Plan abuse, Sun Life can collect, use and disclose information about my claim with relevant organizations. These include my plan sponsor, regulatory bodies, government organizations and other insurers.

Conditions of consent

- My consent is valid for the duration of my claim.
- If the STD or LTD Plan is audited, my claim may become part of the audit.
  - o My consent is valid for the duration of the Plan.
- A photocopy or electronic version of this form is as valid as the original.

Member's last name (please print)	First name

Member's signature	Date (dd-mm-yyyy)
X	

Instructions on how to submit your completed form(s) can be found on the next page.

8 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.

If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.

You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to *disabilityclaims@sunlife.com*. Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below for the Sun Life Group Disability Management Office that manages your claims. 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

9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.