Plan Member's Statement Claim for Short-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.

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 your Short-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 (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	Email 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

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.

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

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

On what date did you first see a doctor for this illness? Date (dd-mm-yyyy)

490S-M-ARA-E-08-13 (G3394-E)

3 About your illness or injury (continued)

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.)

When was your last day of full-time duties/hours? Date (dd-mm-yyyy) – –

When was your last day of modified work (if applicable)? Date (dd-mm-yyyy) – –

What is the date you returned or expect to return to work? Date (dd-mm-yyyy) – –

During this period, have you worked at any occupation or employment? ☐ No ☐ Yes If yes, please explain.

What are the current symptoms preventing you from working?

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.

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? ☐ Yes ☐ No 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 – –

4 Disability as a result of an accident (continued)

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	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	☐	☐		☐	☐	☐	☐	$

6 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.

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 my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

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 last name (please print)	First name

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

Visit our website:
www.sunlife.ca/health and work

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 Sun Life Assurance Company of Canada Group Disability Management Office listed below. 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.

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

7 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 email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.