



Plan Sponsor'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.

1 Plan Member information

Sun Life Assurance Company of Canada must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety in order to avoid delays.

First name	Last name (Quebec residents – maiden name)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy) _ _
Address (street number and name)			Apartment or suite
City	Province	Postal code	
Home telephone number _ _	Alternate telephone number _ _		
Regular occupation title/Job name			

2 Plan Sponsor information

Please also submit the form, Disability Job Demands Questionnaire if the member is expected to be absent for 4 weeks or more.

Contract number	Sub./Class	Member ID	Division/Billing group number
Company name			
Address (street number and name)			
City	Province	Postal code	
Contact person			
Contact's telephone number _ _	Ext.	Email address	

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Date member started with the company (dd-mm-yyyy) _ _	Last date of full-time duties/hours (dd-mm-yyyy) _ _	Last date of modified work (if applicable) (dd-mm-yyyy) _ _
Was the member's employment terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, on what date? <input type="text" value="Date (dd-mm-yyyy)"/>
To the best of your knowledge, why did the member stop working?		

3 Employment information (continued)

Date member returned to full-time duties (dd-mm-yyyy) — —		Date member returned to modified work (dd-mm-yyyy) — —	
If applicable, please describe modifications			
Employment class (check one box in each row)			
a) <input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	How many hours per week? _____	
b) <input type="checkbox"/> Permanent	<input type="checkbox"/> Contract	<input type="checkbox"/> Temporary	<input type="checkbox"/> Seasonal
c) <input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried	<input type="checkbox"/> Commissioned	
d) <input type="checkbox"/> Union			
Is the member involved in shift work? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide details of the actual rotation schedule for the three months prior to the disability date and the planned schedule for the claimed disability period.			

4 Coverage information

Date member's Short-Term Disability coverage became effective with Sun Life Assurance Company of Canada (dd-mm-yyyy) — —	Date member's Long-Term Disability coverage became effective with Sun Life Assurance Company of Canada (dd-mm-yyyy) — —
Was the member's coverage in force on the last day worked? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide date and reason (e.g. layoffs)	

5 Earnings and benefit information

Member's regular salary at the last date worked \$ _____ per week		Less Federal/Provincial income tax \$ _____	
Date this salary became effective (dd-mm-yyyy) — —		Last day member's salary was paid (dd-mm-yyyy) — —	
Average monthly commissions earned in the last 24 months. \$ _____		If applicable, please provide a copy of the tax information slips issued for the past two years for this commissioned member.	
Total personal income tax exemptions according to the last TD1 form (Federal) \$ _____	Total personal income tax exemptions according to the last TP-1015-3V form (Quebec residents only) \$ _____	Social Insurance Number	

- Is the plan under which this member is covered taxable? No Yes
If yes, please provide the Social Insurance Number above for the member as it is required for the issuance of the applicable tax information slip(s).
- Did the member have any scheduled vacation days after the last day worked? No Yes
If yes, how many days? _____
- Does the member have unused sick leave? No Yes If yes, how many days? _____
- What income, if any, does the member receive from you during the absence? Please provide dates and amounts.

How long will this income continue?

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What income, if any, does the member receive (or will receive) during the course of this claim from your retirement or pension plan?

5 Earnings and benefit information (continued)

5. Is the member entitled to any other benefits from any other source (e.g. WCB/WSIB/CSST/CPP/QPP)?

No Yes If *yes*, please describe.

From what date?

Date (dd-mm-yyyy)

– –

6. If the disability is due to pregnancy, has or will the member receive any maternity leave? No Yes

Date maternity leave begins

Date (dd-mm-yyyy)

– –

Date maternity leave ends

Date (dd-mm-yyyy)

– –

7. Are modified duties available? No Yes

Were modified duties offered? No Yes If *yes*, please describe duties (part-time/full-time/modified).

Did the member accept modified duties if offered? Yes No If *no*, please provide details below.

6 Declaration

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

Last name of person signing this statement (please print)	First name	Position
Authorized signature X		Date (dd-mm-yyyy) – –
Telephone number – –	Fax number – –	

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

Please fax or mail this form to the address noted below:

Automotive Retailers Association
Unit #1 – 8980 Fraserwood Court
Burnaby, BC V5J 5H7
Fax: (604) 419-0299