Long-Term Disability
Plan Member Package

How to use this package:

REVIEW	• The links below will take you to the Long-Term Disability (LTD) Claim Guide, a Plan Member's Statement and the Attending Physician's Statements included in this package. • The "Return to Introductory Page" link on each document will take you back to this page. • The LTD Claim Guide is designed to answer questions you may have regarding the claim submission process. • There are three Attending Physician's Statements included, but only one completed Statement is required. Choose the Attending Physician's Statement that best describes your condition. • Read the Authorizations on both the Plan Member's Statement and Part 1 of the Attending Physician's Statements.
COMPLETE	• You are able to save information typed into the forms included in this package. • Complete the Plan Member's Statement in its' entirety. • Complete Part 1 (Plan Member Information) on the applicable Attending Physician's Statement.
PRINT	• Print the complete Plan Member's Statement and sign the Authorization. • Print the appropriate Attending Physician's Statement with Part 1 completed, sign the Authorization and have your physician or specialist complete the form in its entirety. If you are not sure which Attending Physician's Statement to use, take all three to your doctor and he/she will complete the most appropriate form.
SUBMIT	• Send in your completed forms using one of the options provided on the last page of the Plan Member Statement.

- Long-Term Disability Claim Guide
- Plan Member's Statement for Long-Term Disability Benefits
- Attending Physician's Statements for Long-Term Disability Benefits

Life's brighter under the sun

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Long-Term Disability

Claim Guide

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Long-Term Disability (LTD) coverage provides benefits to you when you are disabled. This guide is designed to help you through the claim submission process and to answer any initial questions you may have with respect to filing a claim for Long-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.

When we receive your claim. Your Case Manager reviews all the information received about your claim and the contract provisions. As part of this review, they look at:

- the medical information
- the impact your condition has on your ability to function and carry on your daily activities
- your occupational duties
- how your condition affects your ability to perform your occupation

As part of this review, your case manager will contact you by phone to discuss your claim. They may have some questions for you to better understand your condition, but this is also an opportunity for you to ask them any questions you may have about your claim. They may also need to contact your doctor and/or employer to ask some further questions or to obtain any missing information.

We'll let you know. The claims assessment process usually takes 10 business days after we receive all the necessary information. If your claim is approved based on your employer's LTD plan, your case manager will notify you and your employer by phone and in writing. If your claim is not approved, your case manager will notify you by phone and in writing and provide the reasons for the decision.

Sometimes, not all available information is submitted with a claim. When this information is needed for our assessment of your claim, your case manager will let you know what is needed as soon as possible. In order to prevent delays, it is important that you submit all medical information available with your claim.

Your information is confidential. We treat the information you provide to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's Statement, or as permitted or required by law.

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Reporting your absence

To apply for LTD benefits, you and your employer will need to send us a completed LTD form package. The package contains three forms:

- A Plan Sponsor's Statement, which your employer completes and sends to us separately;
- A Plan Member's Statement, which you must complete and return to our office.
- An Attending Physician's Statement, which you take to your doctor to complete.

NOTE: Your doctor may charge you a fee to complete this form. If so, you will be responsible for paying that fee.

Complete the Plan Member's Statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence.
- Include a description of your job duties and resume with previous job experience and education history. You can include additional paper with the form if you need more space.
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Provide the required document outlined in the "Automatic deposit of your disability payments" section if you would like to have your payments deposited into your bank account. For chequing accounts, we will require a personalized VOID cheque.
- Read and sign the Authorization which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. Also, please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.

Have your physician complete the Attending Physician's Statement

There are three different Attending Physician's Statements provided, but only one completed Statement is required. Chose the Attending Physician Statement that best describes your medical condition and provide it to your doctor for completion. If you are unsure which one to use, take all three to your doctor and he/she will complete the most appropriate form. This Statement provides us with specific medical information about your condition and your expected recovery.

- The Attending Physician's Statement must include all the information requested about your condition. This form can be completed by your family doctor, a doctor at a walk-in clinic, a specialist, etc – any medical professional who is a doctor of medicine and that has treated you for your condition.
- If your doctor has conducted tests, a copy of the findings must be included with the Statement.
- If you have seen a specialist for your condition, be sure to have your doctor send us copies of all consultation and clinical notes with the Statement.

NOTE: Do not change or write anything on the Attending Physician's Statement. Any changes to the Statement must be initialed by your doctor.

Sending in your forms

- Follow up with your doctor (if the form was left with them for completion) and employer to confirm they have completed, signed and submitted their forms to our office.
- We recommend you submit the completed claim forms at least eight weeks prior to the first payment date of your LTD. This provides us with sufficient time to review your claim and make a decision well before the first LTD payment date.
- Send in your forms using one of the options provided on the last page of the Plan Member Statement.

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Be sure your group Contract number and your Member ID number are clearly shown on your Plan Member's Statement and Attending Physician's Statement before submitting the forms to us.

If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.

FAQs

We want you to feel comfortable with the Long-Term Disability claims process. This Frequently Asked Questions guide is designed to help you understand more about the process, from claims submission through to your recovery.

What does plan sponsor mean? The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your plan.

What are my Contract and Member ID numbers? The Contract number refers to the document that outlines your plan sponsor/ employers benefits plan with Sun Life Financial. The Member ID is the number used to identify you specifically. These numbers can be found on your coverage or enrollment summary or in your employee benefits booklet.

How do I choose the most appropriate Attending Physician's Statement? You have been provided with three different Attending Physician's Statements. Only one needs to be completed based on the nature of your medical condition and submitted with your claim. Ask your doctor to complete the form that is most appropriate for your condition.

Why does my doctor need to fill out the Attending Physician's Statement? The Attending Physician's Statements have been designed to ask your doctor for information that will help us understand the nature of your condition and how it impacts your functional abilities. If your doctor provides only part of the information requested, or a brief note on a doctor's prescription pad, we may not have all the information needed to assess your request for benefits. This will potentially delay a decision on your claim.

What does Waiver of Premium mean? Some Group Disability plans provide for coverage that waives the premiums required for certain benefits while you are entitled to Disability benefits under the plan. This means that for the period you are considered totally disabled under the plan, you or your employer will not need to pay the premiums for the coverage of these benefits. Your Benefits Administrator would be able to confirm if your plan has Waiver of Premium coverage. If your plan does contain this coverage, and you are submitting a claim for Long-Term Disability benefits, a claim would automatically be made for any Waiver of Premium benefits that you may be eligible for. You will be advised of the status of your entitlement to the Waiver of Premium benefit along with the status of your LTD claim.

How are my benefits calculated? Disability benefit payments are usually based on a specific percentage of your monthly earnings at the time you become disabled. The benefit amount under your plan is specified in your employee benefits booklet.

If my claim is approved, when do my payments start? Your disability benefit payments will be paid from the day following the completion of the elimination period. The elimination period is outlined in your employee benefits booklet. If this date is in the past, then payment will be made back to this date, for the retroactive amount owing.

How and when are payments made once the claim is approved? If you would like to have your benefits deposited directly into your bank account, the Plan Member's Statement outlines what information is needed in order to set this up - see *Automatic deposit of your disability payments*. Don't forget to review this section and provide the required documentation. For chequing accounts, we will require a personalized VOID cheque. NOTE: There may be a delay in payment if a scheduled payment falls on a holiday.

How long will I receive disability payments? For LTD, you will continue to receive disability benefit payments as long as you meet the definition of total disability as defined in your employee benefits booklet and satisfy other obligations (such as pursuing appropriate treatment) as also described in your benefits booklet. Generally speaking, we consider whether you are 'totally disabled' from your own occupation for a defined period of time following the elimination period. After this period of time, we then consider whether you are 'totally disabled' from any occupation. In the event that you remain continuously and totally disabled, benefits do not continue indefinitely. Your benefits booklet will refer to other critical dates relating to when your benefits end, including the date on which you reach age 65, retire, or die, whichever occurs first. Please consult your employee benefits booklet for the specific details of your plan.

What are my responsibilities while I receive disability benefits? While you are in receipt of disability benefits, we will talk to you about returning to work, at the appropriate time. We expect that you will participate in these discussions, and return to your own occupation as soon as it is safe and healthy for you to do so. If it becomes apparent that you will not be able to return to your own occupation, you will be expected to consider any reasonable offer of modified work with your employer and/or participate in any training required to qualify for an alternate occupation.

Once I've been approved for benefits, how often is medical information requested? A clear understanding of the progress of your recovery is considered essential in preparing for a potential return to work. Periodic updates on your medical condition and functional status help us determine your progress. The frequency of status reports will be determined by the unique circumstances of your claim, your medical condition and treatment plan. We will follow up with you and your treating doctor(s) by telephone or mail. Your Abilities Case Manager will work with your doctor and Sun Life's Health Partners to ensure you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam to get more information. We will arrange the appointment and give you adequate advance notice. (We will provide a copy of the results to your treating doctor.)

When would benefits not be paid? Benefits may not be paid if you:

- are not considered totally disabled
- are not receiving or following appropriate treatment as recommended by your treating doctor
- are on leave of absence, strike or lay-off, except where Sun Life specifically agreed to the continuation of coverage or may be required to by law
- are absent from Canada due to any reason, except where Sun Life specifically agreed to the continuation of coverage or as required by law
- complete any work for wage or profit except as approved by us
- serve a prison sentence or are confined in a similar institution

Please consult your employee benefits booklet for the specific details of your plan.

What if I receive income from another source? How will that impact my benefit? Your employer's LTD plan may indicate that your disability benefit payments are reduced by payments received from other sources, such as Canada Pension Plan (CPP), Quebec Pension Plan (QPP) and Workers' Compensation for the same or subsequent disability. Your benefit payment will not be reduced by income you receive from an individual disability plan. A retroactive award from another source may reduce your disability benefit payments and may result in an overpayment. If this situation occurs, you are expected to reimburse the amount overpaid.

Does Sun Life share medical information with my employer? No. All medication, diagnosis and treatment information obtained by Sun Life concerning your health is strictly confidential and not shared with anyone at your employer unless specifically outlined in the authorization you have signed on your Plan Member's Statement. We do not share medication, diagnosis and treatment information with your manager or Human Resources department at work.

What if I return to work with some restrictions? Your Abilities Case Manager will work with you and your employer to develop a return-to-work plan that accommodates what you are able to do. Your return-to-work plan could include, for example, a gradual increase in hours and/or modified duties. Should your return to work require specific vocational expertise, we may involve one of our Health Management Consultants to assist with planning your return to the workplace. We will contact your doctor to ensure he or she is aware of the plan before it begins. Once you're back performing the essential duties of your occupation, full-time, Sun Life is usually no longer involved.

Will I receive a tax slip? A tax slip will be issued if the disability benefit payments you receive are taxable income. Tax slips are mailed by the end of February every year, for the previous tax year. If you are unsure if the disability benefits payments you receive are taxable income, please contact your Benefits Administrator.

* This guide is not intended to replace or amend your employee benefits booklet. If there are any discrepancies between your employee benefits booklet and the information in this guide, the group benefits booklet will take priority.

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than five million people in over 10,000 corporate, association, affinity and creditor groups across Canada. Our core values — integrity, service excellence, customer focus and building value — are at the heart of who we are and how we do business.

Our extensive products, services and technology enable us to tailor group benefit programs to meet virtually any customer's needs competitively and cost effectively.

Sun Life Financial and its partners have operations in key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
a member of the Sun Life Financial group of companies.
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Sun Life Financial

Clear

Plan Member's Statement
Claim for Long-Term Disability benefits

Sun Life

Sun Life Assurance Company of Canada (Sun Life), 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 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 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

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

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

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

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3 About your illness or injury (continued)

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

   If there was a delay in seeking treatment, please explain and provide dates.

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

6. What treatments are you presently receiving (medications, physiotherapy, psychotherapy, etc.)?

7. 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.

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

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

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

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4 Your general medical history

Attach extra sheets, if necessary.

1. Please list names and addresses of all hospitals where you have been treated during the past three years, including any type of surgery.

Hospital	Address	Nature of illness/surgery	Date (dd-mm-yyyy)

Attach extra sheets, if necessary.

2. List all the doctors you have seen during the past three years for any other illness or injury.

Doctor	Address	Nature of illness	Date (dd-mm-yyyy)

5 Disability as a result of an accident

1. Is your disability the result of an accident?

☐ No If no, continue with the next section **"Workers' Compensation".**

☐ 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 If yes, please ensure you complete the section "Workers' Compensation".

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

5 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 (street number and name)	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.

6 Workers' Compensation

1. If your illness or injury is work related, have you applied for Workers' Compensation benefits? ☐ No ☐ Yes If no, please explain.

2. Are you receiving, or do you expect to receive, Workers' Compensation benefits? ☐ No ☐ Yes If yes, please continue.

What is the claim number? How much is the benefit per month? $

3. Have you received a permanent disability award?

☐ No ☐ Yes If yes, when did you receive it? Date (dd-mm-yyyy)

Was it a monthly benefit? ☐ No ☐ Yes If yes, what was the amount? $

Was it a lump sum settlement? ☐ No ☐ Yes If yes, what was the amount? $

4. If your claim has been denied or terminated, have you appealed the decision?

☐ No ☐ Yes If yes, when did you appeal it? Date (dd-mm-yyyy)

Please indicate the stage of your appeal (if known).

☐ Oral ☐ Board of review ☐ Medical panel ☐ Medical review ☐ Other

7 Canada/Quebec Pension Plan Benefits

1. Have you applied for any disability/retirement benefits from Canada/Quebec Pension Plan?

☐ No ☐ Yes If yes, when did you apply? Date (dd-mm-yyyy)

What type of CPP/QPP benefits did you apply for? ☐ Disability ☐ Retirement

7 Canada/Quebec Pension Plan Benefits (continued)

2. If you have applied, what is the status of your application?

☐ **Approved** Have you been approved for: ☐ CPP/QPP *Disability* benefits
☐ CPP/QPP *Retirement* benefits

Please include a copy of the Notice of Entitlement and Payment Explanation Statement with this form.

Benefit effective date: Date (dd-mm-yyyy) Benefit amount per month: $

☐ **Declined**

Have you appealed the decision?

☐ No ☐ Yes If yes, please provide the date of the appeal: Date (dd-mm-yyyy)

Please provide a copy of the denial letter.

☐ **Decision pending** Please provide any additional details regarding your application/appeal.

3. Provide the following information for any dependent children living with you:

Full name	Relationship to you		Date of birth (dd-mm-yyyy)	If child is 18 or over, check whether child is:	
	Son	Daughter		Handicapped	Full-time student
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

8 Your other income

Please list any amounts of money you are currently receiving or expect to receive each month from the following sources. We may take some of these amounts into consideration when we calculate your Long-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		☐	☐	☐	☐	$	

9 Returning to work

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.

Returning to work is an important part of your treatment program. If you qualify, Sun Life has a program to assist you to return to work. You may be contacted by a Sun Life Health Management Consultant.

1. What discussions have you had with your doctor regarding your return to work, either to your own job (with or without modification), or to another position?

2. What discussions have you had with your employer regarding your return to work, either to your own job (with or without modification), or to another position?

10 Your education, skills and work history

1. Level of education completed: ☐ High School ☐ Community College ☐ University
   What was the highest grade level/year that you completed? Please list any certificates/degrees obtained.

2. Please advise if your education was obtained within Canada or outside of Canada. If obtained outside of Canada, please confirm where.

3. 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. (Attach extra sheets, if necessary.)

4. Do you have a valid driver's license? ☐ No ☐ Yes If yes, Class
   Please give details about any driving restrictions resulting from your disability.

Please provide your work experience. Attach a resume if available.

From (date) (dd-mm-yyyy)	To (date) (dd-mm-yyyy)	Employer	Job title

11 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.

12 Your permission

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 short-term disability (STD) claim or my long-term (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:

- relevant claims information, except for details about my diagnosis and treatment, to manage my accommodation, occupational rehabilitation and return to work.
- financial information related to my claim needed for Plan administration.

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 X		Date (dd-mm-yyyy)

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

13 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

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

14 Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

Attending Physician's Questionnaire Claim for Long-Term Disability Benefits

Sun Life Financial

Please complete this form based on your patient's current medical condition. The information you provide will assist Sun Life Assurance Company of Canada (Sun Life) to understand your patient's condition, treatment, prognosis and potential for recovery. Thank you for your time and cooperation.

Please note that any reference to Attending Physician (doctor) also refers to Licensed Physician or Nurse Practitioner.

NOTE: There are three Questionnaires included in your patient's LTD package – Mental Health, Musculoskeletal and one for other conditions. Only one form needs to be completed. Please choose the form most appropriate for your patient's condition. Your patient is responsible for any cost associated with the completion of this form.

1 Plan Member information and authorization (to be completed by your patient)

First name	Last name	☐ Male ☐ Female
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home telephone number	Alternate telephone number	
Email address		

Contract number	Member ID number	Height ft in. / m cm	Weight ☐ lbs. ☐ kg	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

Please list your present medications

Name of medication	Dosage (mg)	How often?

Member's consent & signature

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this consent is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this consent or electronic version is as valid as the original. Please note that genetic testing information is not required, so please do not include.

Plan member signature	Date (dd-mm-yyyy)
X	

2 About the condition (to be completed by the doctor)

Plan member's first name	Last name	Date of birth (dd-mm-yyyy)

I am the: ☐ Attending physician ☐ Consulting specialist ☐ Other (please specify) _____

Current diagnosis

Primary
Secondary

Has the diagnosis been communicated to your patient? ☐ Yes ☐ No

Is this condition related to:

☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act If so, date of event: Date (dd-mm-yyyy)

Details

First date of work absence due to this condition (dd-mm-yyy)	Date of first visit to you for this condition (dd-mm-yyy)

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No If yes,

Date (dd-mm-yyyy)	By whom

Have you completed any other disability claim forms recently for your patient? ☐ No ☐ Yes

Symptoms

Please describe your patient's current symptoms, including frequency and severity.

Symptom	Frequency	Severity

How have your patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ Retrogressed

If childbirth: expected or actual delivery date ☐ Vaginal ☐ C-Section Date (dd-mm-yyyy)

3 Clinical findings and observations

Investigations

Please attach copies of all relevant:
- test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Please note that genetic testing information is not required, so please do not include.

Are tests and/or investigations pending? ☐ No ☐ Yes If yes,

Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description

If you are not the treating specialist, is your patient currently under the care of a specialist? ☐ No ☐ Yes

If yes, please attach copies of consultation reports. If consultation reports are not attached or not yet received, please provide the following:

Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)
Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)

Findings

Has any formal functional testing been done (e.g., functional abilities evaluation)? ☐ Yes ☐ No

If yes, please attach a copy of the report.

Please indicate if your patient has reported or exhibited any difficulty, and if so, level of difficulty with the following:

	None	Slight	Moderate	Severe	Is this consistent with physical or cognitive findings? Please comment.
Memory	☐	☐	☐	☐	
Decision making	☐	☐	☐	☐	
Concentration/Focus	☐	☐	☐	☐	
Speech	☐	☐	☐	☐	
Sleep	☐	☐	☐	☐	
Sensation	☐	☐	☐	☐	
Dexterity	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Reaching above shoulder	☐	☐	☐	☐	
Reaching below shoulder	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	

3 Clinical findings and observations (continued)

Based on your clinical findings and observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Cardiac conditions

If the condition is related to a cardiac event, please provide the following:

Type of symptom	Description
☐ Chest pain of cardiac origin	
☐ Syncope	
☐ Fatigue	
☐ Dyspnea due to vascular congestion or hypoxia	
☐ Psychophysiologic	
☐ Other	

BP readings over last 6 months (including date) _____

Current status? ☐ Stable ☐ Improving ☐ Regressing

What is the functional capacity (American Heart Association)? If class 3 or 4, please include a copy of any stress tests or cardiac echograms.

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Is angina the limiting exercise factor? ☐ Yes ☐ No

Complicating factors

Current height _____ Current weight _____ Weight loss/gain to date _____

Is your patient in a weight reduction program? ☐ Yes ☐ No If yes, please provide details.

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate your patient's recovery period.

☐ Workplace issues ☐ Social/family issues ☐ Financial/legal problems ☐ Self-harm behavior ☐ Physical condition
☐ Alcohol/drug use ☐ Medication side effects ☐ Pain perception ☐ Coping skills ☐ Personality/motivation
☐ Other

Please describe.

3 Clinical findings and observations (continued)

Please describe the supports in place, or planned, to assist with these issues.

Has any licence held by your patient been restricted or revoked as a result of this condition? ☐ Yes ☐ No If yes, as of when?

Date (dd-mm-yyyy)	Type of license

4 Treatment

Has your patient recently been hospitalized for their current condition? ☐ Yes ☐ No

If yes, please provide copies of the hospital discharge summary. If this is not available, please provide the following:

Date of any hospitalizations

Date of admission (dd-mm-yyyy)	Date of discharge (dd-mm-yyyy)	Institution name

If surgery was/will be performed, please provide date(s) and description of surgery(s).

Date (dd-mm-yyyy)	Description

How long has your patient been under your care?

Date of last visit (dd-mm-yyyy)	Date of next scheduled visit (dd-mm-yyyy)

Since the first visit, how often have you seen your patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other

Medications prescribed by you (only those not identified by the member in section 1)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

Medications prescribed by other physician(s)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

4 Treatment (continued)

Treatment details (e.g. physiotherapy, pain management, chiropractic, psychotherapy, cognitive behavioural, massage, exercise, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Overall response to treatment

Please describe the response to treatment to date. ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is your patient following the recommended treatment program? ☐ Yes ☐ No If no, please explain.

Are there any plans to change or augment the current treatment program? ☐ Yes ☐ No If so, please explain.

5 Prognosis and recovery

Sun Life encourages rehabilitation assistance, modified work or light duties to return an employee to the workplace as soon as medically possible. Based on the information you have provided we will review your patient's rehabilitation potential.

What return-to-work goals have been discussed with your patient? Please explain.

Please provide your patient's prognosis for improvement.

Please provide any other information that will help us understand your patient's current condition, recovery goals and prognosis.

6 Attending physician's acknowledgement

The information in this statement will be kept in a disability file with the insurer or plan administrator and may be disclosed to the patient, third parties who have been authorized by the patient or Sun Life's agents and service providers having a right to access the information.

By providing this information, I consent to the unedited release of any information in this form. I understand that I must notify you in writing if there is a significant likelihood that such disclosure to either the patient or a third party authorized by the patient would adversely affect the health of the patient.

<table>
<tr><td>Last name of attending physician (please print)</td><td>First name</td><td colspan="2">Certified specialist</td><td rowspan="5">Physician's stamp</td></tr>
<tr><td colspan="4">Address (street number and name)</td></tr>
<tr><td colspan="2">City</td><td>Province</td><td>Postal code</td></tr>
<tr><td colspan="2">Telephone number</td><td colspan="2">Fax number</td></tr>
<tr><td colspan="4">Physician's signature
X</td><td>Date signed (dd-mm-yyyy)</td></tr>
</table>

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

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Montreal:
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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

Attending Physician's Questionnaire Claim for Long-Term Disability Benefits *Musculoskeletal Conditions*

Sun Life Financial

Please complete this form based on your patient's current medical condition. The information you provide will assist Sun Life Assurance Company of Canada (Sun Life) to understand your patient's condition, treatment, prognosis and potential for recovery. Thank you for your time and cooperation.

Please note that any reference to Attending Physician (doctor) also refers to Licensed Physician or Nurse Practitioner.

NOTE: There are three Questionnaires included in your patient's LTD package – Mental Health, Musculoskeletal and one for other conditions. Only one form needs to be completed. Please choose the form most appropriate for your patient's condition. Your patient is responsible for any cost associated with the completion of this form.

1 Plan Member information and consent (to be completed by patient)

First name	Last name	☐ Male ☐ Female
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home telephone number	Alternate telephone number	
Email address		

Contract number	Member ID number	Height ft in. / m cm	Weight ☐ lbs. ☐ kg	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

Please list your present medications

Name of medication	Dosage (mg)	How often?

Member's consent & signature

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this consent is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this consent or electronic version is as valid as the original. Please note that genetic testing information is not required, so please do not include.

Plan member signature	Date (dd-mm-yyyy)
X	

Return to Introductory Page

2 About the condition (to be completed by doctor)

Plan member's first name	Last name	Date of birth (dd-mm-yyyy)

I am the: ☐ Attending physician ☐ Consulting Specialist ☐ Other (please specify) _____

Current diagnosis

Primary
Secondary

Has the diagnosis been communicated to your patient? ☐ No ☐ Yes

Is this condition related to:

☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act If so, date of event: Date (dd-mm-yyyy)

Details

Date of first visit to you for this condition (dd-mm-yyyy)	First date of work absence due to this condition (dd-mm-yyyy)

Has the patient been treated for this same or similar condition in the past? ☐ No ☐ Yes If yes,

Date (dd-mm-yyyy)	By whom

Have you completed any other disability claim forms recently for your patient? ☐ Yes ☐ No

Symptoms

Please describe your patient's current symptoms, including frequency and severity.

Symptom	Frequency	Severity

How have your patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ worsened

3 Clinical findings and observations

Investigations

Please attach copies of all relevant:

- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Please note that genetic testing information is not required, so please do not include.

Are tests and/or investigations pending? ☐ No ☐ Yes If yes,

Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description

If you are not the treating specialist, is your patient currently under the care of a specialist? ☐ No ☐ Yes

If yes, please attach copies of consultation reports. If consultation reports are not attached or not yet received, please provide the following:

Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)
Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)

Please confirm your patient's Weight _____ Height _____

Is your patient in a weight reduction program? ☐ Yes ☐ No

Neurological findings

Weakness present: ☐ Yes ☐ No

Muscle wasting noted: ☐ Yes ☐ No

Decreased sensation or numbness present: ☐ Yes ☐ No

Reflexes: ☐ Normal ☐ Diminished ☐ Absent

Please describe the affected joint or muscle group.

3 Clinical findings and observations (continued)

Range of motion

List affected joint(s) and/or muscle group(s)
(Note: Specify findings if more than one joint is involved)

1. _____
2. _____
3. _____
4. _____

Please provide applicable ROM findings (in degrees), for each affected joint/muscle group as numbered to the left.

	1	2	3	4
Flexion				
Lateral flexion				
Extension				
Internal rotation				
External rotation				
Abduction				
Adduction				
Rotation				
Supination				
Pronation				
Grip strength				
Straight leg raising	Sitting Lt. / Rt.		Lying Lt. / Rt.	

Functional evaluation

Has any formal functional testing been done (e.g., functional abilities evaluation)? ☐ No ☐ Yes If yes, please attach a copy of the report.
Please indicate if your patient has reported or exhibited any difficulty, and if so, level of difficulty with the following:

	None	Slight	Moderate	Severe	Is this consistent with physical or cognitive findings? Please comment.
Cognition	☐	☐	☐	☐	
Sensation	☐	☐	☐	☐	
Dexterity	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Reaching above shoulder	☐	☐	☐	☐	
Reaching below shoulder	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	

Provide an estimated maximum that your patient can lift
☐ (0-10 lbs) ☐ (11-20 lbs) ☐ (21-30 lbs) ☐ (31-40 lbs) ☐ (41-50 lbs) ☐ (50 lbs +)

Return to Introductory Page

3 Clinical findings and observations (continued)

Please comment on any additional medical conditions or complications impacting your patient's level of function or the expected recovery period.

Complicating factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate your patient's recovery period.

☐ Workplace issues ☐ Social/family issues ☐ Financial/legal problems ☐ Physical condition ☐ Alcohol/drug use
☐ Medication side effects ☐ Pain perception ☐ Coping skills ☐ Personality/motivation ☐ Other

Please describe.

Please describe the supports in place, or planned, to assist with these issues.

Has any licence held by your patient been restricted or revoked as a result of this condition? ☐ No ☐ Yes If yes, as of when?

Date (dd-mm-yyyy)	Type of licence

4 Treatment

How long has your patient been under your care? _____

Date of last visit (dd-mm-yyyy)	Date of next scheduled visit (dd-mm-yyyy)

Since the first visit, how often have you seen your patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Medications prescribed by you (only those not identified by the member in section 1)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/comments

Medications prescribed by other physician(s)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/comments

4 Treatment (continued)

Treatment details – Please provide details of the current treatment program (e.g. physiotherapy, pain management, chiropractic, psychotherapy, cognitive behavioural, massage, exercise, other rehabilitation therapy, etc)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Has your patient recently been hospitalized for their current condition? ☐ No ☐ Yes

If yes, please provide copies of the hospital discharge summary. If this is not available, please provide the following:

Date of any hospitalizations

Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)	Institution name

Has surgery been performed or is it planned? ☐ No ☐ Yes If yes, indicate the type of surgery.

Surgery	
Date performed (dd-mm-yyyy)	Date planned (dd-mm-yyyy)

Overall response to treatment

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is your patient following the recommended treatment program? ☐ No ☐ Yes

If no, please explain.

Are there any plans to change or augment the current treatment program? ☐ No ☐ Yes

If yes, please explain.

5 Prognosis and recovery

Sun Life encourages rehabilitation assistance, modified work or light duties to return an employee to the workplace as soon as medically possible. Based on the information you have provided we will review your patient's rehabilitation potential.

What return-to-work goals have been discussed with your patient? Please explain.

Please provide your patient's prognosis for improvement.

Please provide any other information that will help us understand your patient's current condition, recovery goals and prognosis.

6 Attending physician's acknowledgement

The information in this statement will be kept in a disability file with the insurer or plan administrator and may be disclosed to the patient, third parties who have been authorized by the patient or Sun Life's agents and service providers having a right to access the information.

By providing this information, I consent to the unedited release of any information in this form. I understand that I must notify you in writing if there is a significant likelihood that such disclosure to either the patient or a third party authorized by the patient would adversely effect the health of the patient.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address (street number and name)			
City	Province	Postal code	
Telephone number	Fax number		
Physician's signature X			Date signed (dd-mm-yyyy)

Return this statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

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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

Attending Physician's Questionnaire Claim for Long-Term Disability Benefits *Mental Health Condition*

Sun Life Financial

Please complete this form based on your patient's current medical condition. The information you provide will assist Sun Life Assurance Company of Canada (Sun Life) to understand your patient's condition, treatment, prognosis and potential for recovery. Thank you for your time and cooperation.

Please note that any reference to Attending Physician (doctor) also refers to Licensed Physician or Nurse Practitioner.

NOTE: There are three Questionnaires included in your patient's LTD package – Mental Health, Musculoskeletal and one for other conditions. Only one form needs to be completed. Please choose the form most appropriate for your patient's condition. Your patient is responsible for any cost associated with the completion of this form.

1 Plan member information and consent (to be completed by the patient)

First name	Last name	☐ Male ☐ Female
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home telephone number	Alternate telephone number	
Email address		

Contract number	Member ID number	Height ft in. / m cm	Weight ☐ lbs. ☐ kg	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

Please list your present medications

Name of medication	Dosage (mg)	How often?

Member's consent & signature

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this consent is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this consent or electronic version is as valid as the original. Please note that genetic testing information is not required, so please do not include.

Plan member signature	Date (dd-mm-yyyy)
X	

Return to Introductory Page

2 About the condition (to be completed by doctor)

Plan member's first name	Last name	Date of birth (dd-mm-yyyy)

I am the: ☐ Attending physician ☐ Consulting psychiatrist, Consulting psychologist ☐ Other (please specify) _____

Current diagnosis

Primary
Secondary

Has the diagnosis been communicated to your patient? ☐ Yes ☐ No

Is this condition related to:

☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act If so, date of event: Date (dd-mm-yyyy)

Details

First date of work absence due to this condition (dd-mm-yyy)	Date of first visit to you pertaining to this condition (dd-mm-yyy)

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No If yes,

Date (dd-mm-yyyy)	By whom

Have you completed any other disability claim forms recently for your patient? ☐ No ☐ Yes

Symptoms

Please describe your patient's current symptoms, including frequency and severity.

Symptom	Frequency	Severity

How have your patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ Worsened

3 Clinical findings and observations

If you are not the treating specialist, is your patient currently under the care of a specialist? ☐ No ☐ Yes

If yes, please attach copies of consultation reports. If consultation reports are not attached or not yet received, please provide the following:

Name of specialist	Specialty	Date of appointment (dd-mm-yyyy)
Name of specialist	**Specialty**	**Date of appointment (dd-mm-yyyy)**

Please describe how the condition is impacting the following and to what degree.

	No impact	Mild	Moderate	Severe
Appearance (Self Care)	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy/vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration/focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect/mood	☐	☐	☐	☐
Insight/judgement	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Weight and/or Appetite	☐	☐	☐	☐

Observations or comments supporting how the condition is impacting your patient.

Complicating factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate your patient's recovery period.

☐ Workplace issues ☐ Social/family issues ☐ Financial/legal problems ☐ Self-harm behavior ☐ Physical condition
☐ Alcohol/drug use ☐ Medication side effects ☐ Pain perception ☐ Coping skills ☐ Personality/motivation
☐ Other

Please describe.

Return to Introductory Page

3 Clinical findings and observations (continued)

Please describe the supports in place, or planned, to assist with these issues.

Has any licence held by your patient been restricted or revoked as a result of this condition? ☐ No ☐ Yes If yes, as of when?

Date (dd-mm-yyyy)	Type of licence

Investigations

Please attach copies of all relevant:
- test results/investigations (If test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Please note that genetic testing information is not required, so please do not include.

Are tests and/or investigations pending? ☐ No ☐ Yes If yes,

Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description
Date report expected (dd-mm-yyyy)	Description

4 Treatment – Special programs, therapies, medications

How long has your patient been under your care? _____

Date of last visit (dd-mm-yyyy)	Date of next scheduled visit (dd-mm-yyyy)

Since the first visit, how often have you seen your patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

Has your patient been treated for this same or similar condition in the past? ☐ Yes ☐ No If yes, date. Date (dd-mm-yyyy)

Treatment provider

Medications prescribed by you (only those not identified by the member in section 1)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

Medications prescribed by other physician(s)

Medication	Dosage	Date started (dd-mm-yyyy)	Response/Comments

4 Treatment – Special programs, therapies, medications (continued)

Treatment details – Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, day hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Treatment details – Concurrent Physical conditions (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd-mm-yyyy)	Frequency of visits	Date of last visit (dd-mm-yyyy)	Response
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		
			☐ Weekly ☐ Monthly ☐ Other		

Has your patient recently been hospitalized for their current condition? ☐ No ☐ Yes
If yes, please provide copies of the hospital discharge summary. If this is not available, please provide the following:

Date of any hospitalizations

Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)	Institution name

Overall response to treatment

Please describe the response to treatment to date: ☐ Complete ☐ Partial ☐ None ☐ Too soon to tell

Is your patient following the recommended treatment program? ☐ No ☐ Yes
If no, please explain.

Are there any plans to change or augment the current treatment program? ☐ No ☐ Yes
If yes, please explain.

5 Prognosis and recovery

Sun Life encourages rehabilitation assistance, modified work or light duties to return an employee to the workplace as soon as medically possible. Based on the information you have provided we will review your patient's rehabilitation potential.

What return-to-work goals have been discussed with your patient? Please explain.

Please provide your patient's prognosis for improvement.

Please provide any other information that will help us understand your patient's current condition, recovery goals and prognosis.

6 Attending physician's acknowledgement

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By providing this information, I consent to the unedited release of any information in this form. I understand that I must notify you in writing if there is a significant likelihood that such disclosure to either the patient or a third party authorized by the patient would adversely effect the health of the patient.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address (street number and name)			
City	Province	Postal code	
Telephone number	Fax number		
Physician's signature X			Date signed (dd-mm-yyyy)

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