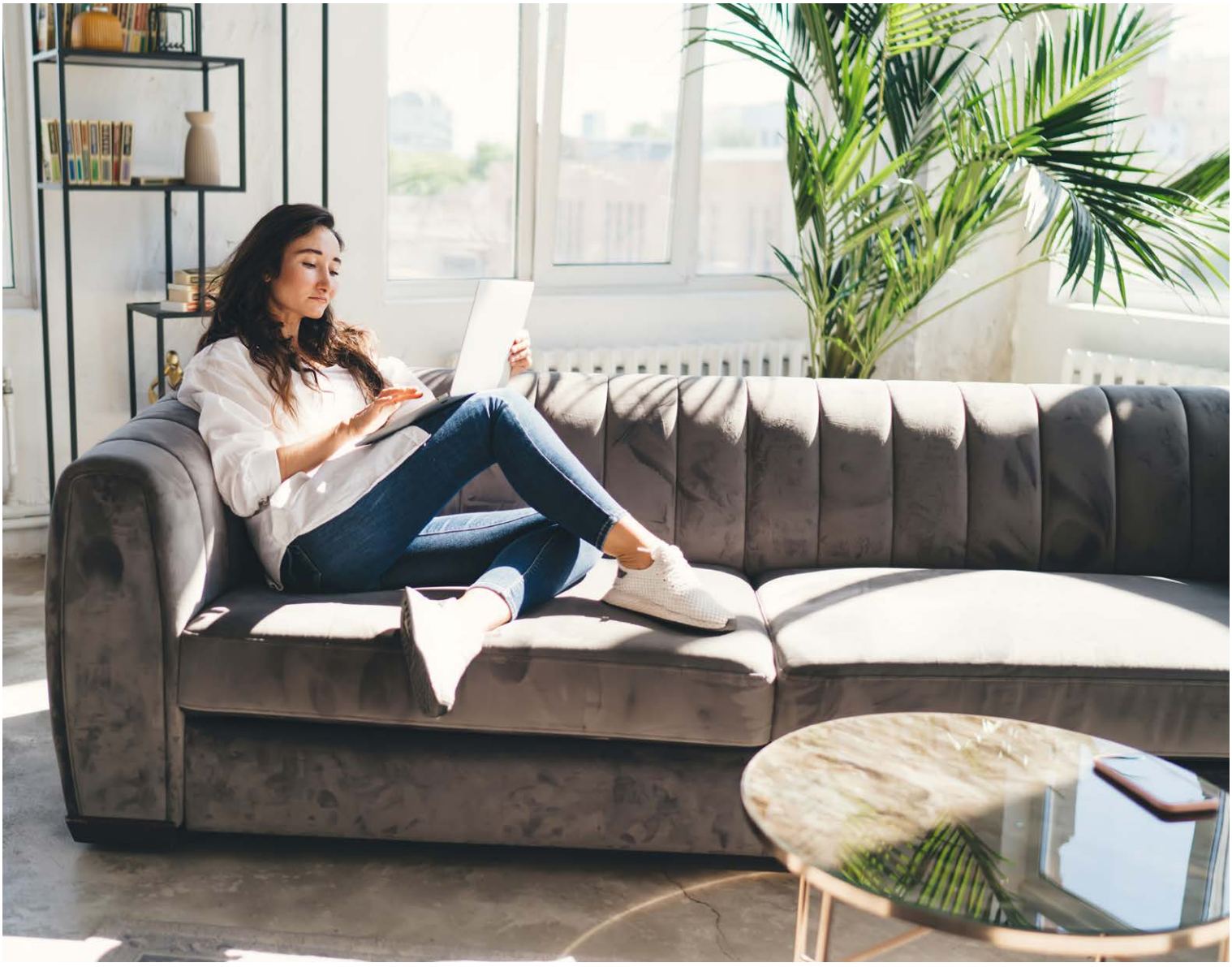
Sun Life

Your guide to reporting your absence

This guide will help you understand what we need to assess your absence so you can focus on your health.



Life's brighter under the sun

Your plan sponsor has asked us to help you through the process of reporting your absence. Follow these steps and, if you have questions, we're here to help.

1.

Fill out and sign the Plan Member Statement. This statement gives us information about your condition, your treatment and your relevant medical history. Return the statement to us using the instructions on the form.

2.

Fill out and sign part 1 of the Attending Physician's Statement. This section of the form confirms your personal information. Signing it allows your doctor or nurse practitioner to exchange information with us.

3.

Ask your doctor or nurse practitioner to fill out the rest of the Attending Physician's Statement. This statement gives us information about your health condition and treatment plan. If your doctor or nurse practitioner charge a fee to fill out forms, you'll need to pay this cost.

What happens next?

- Your employer will fill out a **Plan Sponsor Statement form** and send it to us.
- Once we receive your employer's **Plan Sponsor Statement**, your **Plan Member Statement**, and the **Attending Physician's Statement**, we'll start our assessment.
- We'll connect with you about next steps. After we receive all three forms, you can expect to hear from us within 5 business days.

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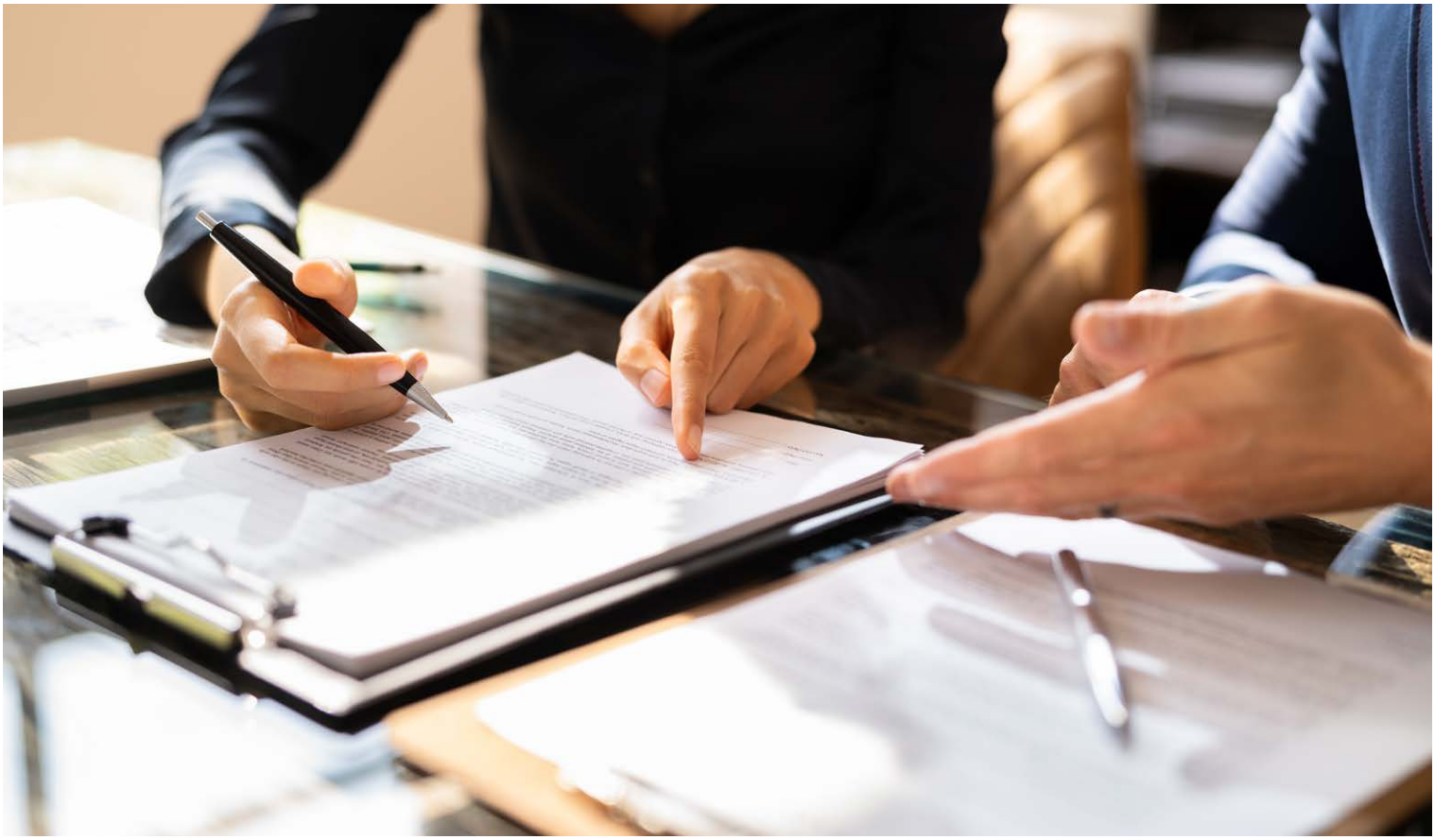
Don't forget!

For the Plan Member Statement:

- ✓ Be sure to answer all the questions in full so we have everything we need to assess your absence. This will help avoid delays.
- ✓ Double check all the dates you provide (for example, the date you were first unable to work, or the date of your accident). These are essential to our assessment.
- ✓ Check with your employer about any deadlines you have for sending us this form.
- ✓ Include your group contract number and your member ID number. If you're unsure about what these numbers are, contact your benefits administrator.

For the Attending Physician's Statement:

- ✓ Sign and date part 1 of the form.
- ✓ Include your group contract number and your member ID number. If you're unsure about what these numbers are, contact your benefits administrator.



Who does what?

Depending on the service your plan sponsor has chosen, we'll provide assessment, case management, or referral services.

For assessment and case management services, we review the medical reasons for your absence. We then make a recommendation to your plan sponsor about whether the medical information supports your absence.

Your **plan sponsor** provides the salary continuance program. They're responsible for deciding whether to continue paying your salary while you're off work.

Terms we use in this guide

Benefits administrator. This is the person who handles human resources questions where you work. Depending on the size of your company, it could be a team of people or a single person.

Plan sponsor. This is typically your employer, but can be a union or other organization that offers a group health plan to its employees or members.

Life's brighter under the sun

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Sun Life

Clear

Plan Member's Statement
Salary Continuance Services

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 absence, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this absence will be your responsibility.**

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		
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. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

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 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.

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.

3 About your illness or injury (continued)

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 declaration and authorization"**.

☐ 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

5 Your declaration and authorization

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 absence(s) from work. I authorize Sun Life to collect, use and disclose information needed for administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan ("this Plan") to any person or organization who has relevant information pertaining to my absence(s) from work 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 absence(s) from work for purposes relevant to the management of this Plan. I understand that information about me pertaining to my absence(s) from work may be reviewed in the event that this Plan is audited.

I authorize Sun Life to collect from and discuss with my Plan Sponsor any information in my Plan Sponsor's file (including diagnosis, treatment or medication) pertaining to my absence(s) and to use such information for the purposes described in the paragraph above.

I also authorize Sun Life and my Plan Sponsor to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **except** for details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I also authorize Sun Life and my Plan Sponsor's medical consultants to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purpose of facilitating in the resolution of any litigation or any other formal legal proceeding (threatened or actual) relating to my absence(s) from work that I may raise or commence against my Plan Sponsor.

I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work that I have disputed, 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 or my 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 (please print)	
Signature X		Date (dd-mm-yyyy)

Please notify Sun Life Assurance Company of Canada and your Plan Sponsor of your expected return to work date.
Instructions on how to submit your completed form(s) can be found on the next page

6 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 Assurance Company of Canada 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

7 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 Statement
Salary Continuance Services

Sun Life Financial

Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada in assessing your patient's absence from work.

Return address

Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Assurance Company of Canada 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.

Edmonton:	Toronto:	Halifax:	Montreal:	Kitchener - Waterloo:	Vancouver:
Fax: 1-866-639-7820	Fax: 1-866-639-7851	Fax: 1-866-639-7850	Fax: 1-866-639-7846	Fax: 1-866-209-7215	Fax: 1-866-639-7829
PO Box 2733 Stn Main	PO Box 950 Stn A	PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Montreal QC H3C 5P5	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6

1 Plan Member information and authorization to be completed by patient

Last name	First name	Home telephone number	Alternate telephone number

Address (street number and name)	Apartment or suite

City	Province	Postal code

Plan Sponsor name	Contract number	Member ID number

Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

I authorize my doctor to collect, use and disclose information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan (the "Plan"). I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work that I have disputed, 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.

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

2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete up to the end of Section 2 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete all sections in full.

Diagnosis

Primary:

Secondary:

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

Occupational illness/injury Is condition arising from employment? ☐ Yes ☐ No

Start dates of current work absence

Date of first visit during current period of absence (dd-mm-yyyy) _____

First date of work absence due to condition (dd-mm-yyyy) _____

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2 Attending Physician's Statement (continued)

Hospitalization

Has your patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy) _____

Have they had day surgery? ☐ Yes ☐ No Date discharged (dd-mm-yyyy) _____

Name of institution: _____

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy) _____ Description _____ Type of anaesthetic _____

Treatment (Drug, dosage, physiotherapy, other)

Prognosis – Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) _____

Visits – Frequency of visits ☐ Weekly ☐ Monthly ☐ Other _____

Symptoms – Describe current symptoms, severity and frequency.

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/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy) _____

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit (dd-mm-yyyy) _____

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

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

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4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life Assurance Company of Canada and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

<table>
<tr><td>Last name of attending physician (please print)</td><td>First name</td><td colspan="2">Certified specialist</td><td rowspan="4">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>Telephone number</td><td colspan="3">Fax number</td></tr>
<tr><td colspan="4">Physician's signature
X</td><td>Date signed (dd-mm-yyyy)</td></tr>
<tr><td colspan="5">NOTE: Your patient is responsible for any charge made for the completion of this form.</td></tr>
</table>