Homewood Health | Santé

Accommodation Services Plan Sponsor Referral Form

Sun Life

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In this form, when we refer to Sun Life, we're including our agents and service providers.

Accommodation Services will provide you with a one-time assessment of a plan member's accommodation request. This is for plan members who are at work and asking for an accommodation to stay at work. Through this service, Sun Life will arrange for a consultation to be provided by a third-party service provider.

This form gives us the information needed for the accommodation assessment. Please complete this form in its entirety to avoid delays.

To request Accommodation Services, please:

- Provide the plan member with the Accommodation Services Plan Member Statement and ask them to complete and return it to you.
- Complete the Accommodation Services Plan Sponsor Referral Form (this form) in its entirety. It gives us the information needed for the accommodation assessment. Submit this form to Sun Life with the Plan Member Statement.
- Provide the plan member with the Accommodation Services Attending Physician Statement, to complete with their doctor. The plan member will send the Attending Physician Statement directly to Homewood Health once completed.

Sun Life commits to keeping plan members' personal information confidential. This statement forms part of the plan member's accommodation services file. We will release this statement to the plan member if they request their file.

1 Fees

If there are additional fees related to this case, you'll be advised ahead of time and will provide approval.

2 Employee Information

First name	Last name	Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home phone number	Alternate phone number	
Plan Member's work email address, if applicable	Regular occupation title/Job name	

3 Employer information

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

4 Accommodation information

Is there curently an accommodation in place? ☐ Yes ☐ No If yes, ☐ temporary ☐ permanent	Was there a previous accommodation? ☐ Yes ☐ No If yes, provide date (dd-mm-yyyy)

Please describe, to the best of your knowledge, the reason for the request for accommodation and any details you may have about the plan member's current situation.

Please describe any modifications that you currently have in place or previously attempted

5 Employment information and job activities

This section asks for information on the employee's specific job duties. We need this part to be filled out by the plan members immediate supervisor or another person who can identify the plan members specific job duties. If there is a prepared job description, Physical Demands Analysis or Cognitive Demands Analysis please attach it to this form.

Date member started with the company (dd-mm-yyyy)

Employment class (check all that apply)

☐ Full-time (25 hours per week or more) ☐ Part-time Regular number of hours per week _____

☐ Permanent ☐ Contract ☐ Temporary ☐ Seasonal

☐ Hourly ☐ Salaried ☐ Commissioned ☐ Union

What is the plan member's regular work schedule? If this varies, please provide a sample work calendar

1. Is the plan member's job a safety sensitive position? ☐ No ☐ Yes ☐ Unknown
2. Does the plan member's job require work in any of the following conditions?:

Outside	☐ No	☐ Yes	If yes, what percentage of time?	%
In a noisy environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a dusty or unventilated environment	☐ No	☐ Yes	If yes, what percentage of time?	%

3. During the plan member's normal routine, what percentage of time does the job require the member to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
More than 20 lbs/9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs/4.5 kg	☐	☐	☐	☐	☐

4. During the plan member's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

5 Employment information and job activities (continued)

5. How much time is the plan member required to maintain the following activities before changing position or activity?

	0 to 30 minutes	30 to 60 minutes	60 to 90 minutes	More than 90 minutes
Sitting at one time	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐

6. During the average day, what is the number of hours the plan member spends in the following positions or activities?

	0 to 2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Driving	☐	☐	☐	☐

7. Cognitive/non-physical aspects of the job

Does the plan member have to answer complaints? ☐ Yes ☐ No

Is the plan member primarily evaluated on production? ☐ Yes ☐ No

Does the plan member work closely with co-workers? ☐ Yes ☐ No

Is the plan member responsible for the performance objectives/decision–making within his/her particular department? ☐ Yes ☐ No

Does the plan member have to analyze complex data? ☐ Yes ☐ No

Is the plan member responsible for reading simple to complex information? ☐ Yes ☐ No

Number of people this plan member supervises: ☐

What percentage of the plan member's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

Please list any other relevant aspects of the job that may be considered stressful.

6 Other remarks

Are there any workplace factors that may impact the accommodation? ☐ Yes ☐ No

Provide any comments or other remarks.

7 Declaration

I am authorized to complete this form on the plan sponsor's behalf. I certify that the statements in this form are true and complete. In place of my handwritten signature, I have typed my name. Both my typed name and an electronic copy of this form are as valid as an original.

Last name of member's supervisor (please print)	First name
Phone number	Email address
Last name of person signing this statement (please print)	First name
Position of person signing this statement (please print)	
Signature X	Date (dd-mm-yyyy)
Phone number	Email address

Please send the completed Plan Sponsor Referral Form along with any supporting documents you may have to review the details of the accommodation request (e.g., medical certificate, job description, etc.), along with the Plan Member Statement, completed by the plan member.

If you have access to our Disability Online Tool, you can use it to submit completed forms electronically.

If you don't have access to the Disability Online Tool, you can send information by email at *disability.claims@sunlife.com*. If you choose to send your information by email, we can't guarantee the privacy or security of email communications while they're on their way to us.

Please retain the original copy for your records.

Accommodation Services Plan Member Statement

Sun Life

Sun Life Assurance Company of Canada (Sun Life) is a member of the Sun Life group of companies.

Your plan sponsor uses Sun Life to help assess employee requests for workplace accommodations due to a new or changing health condition.

- For accommodation assessments, Sun Life engages a service provider. Under this service, the service provider makes recommendations.
- Your plan sponsor will decide whether and how to accommodate you, based on the recommendations and other factors.

Sun Life is committed to keeping your information confidential

To request Accommodation Services:

- Please return this completed form to your plan sponsor. They will send it to Sun Life with their Accommodation Services Plan Sponsor Referral Form.
- Please also complete the Plan member information and authorization (section 1) of the Accommodation Services Attending Physician Statement. Your doctor also has to fill in part of the Accommodation Services Attending Physician Statement. You're responsible for any fees your doctor charges to do so. Please send the Accommodation Services Attending Physician Statement directly to Homewood Health. See Accommodation Services Attending Physician Statement for further instructions.

Last name (please print)	First name (please print)	
Plan sponsor's name		
Member ID	Plan Sponsor's contract number	
Work phone number	Alternate phone number	Preferred language of communication ☐ English ☐ French

Your permission

I understand that my plan sponsor has asked Sun Life for help in assessing my accommodation request.

For accommodation assessments, Sun Life engages Homewood Health as its service provider. The reference to Sun Life, Homewood Health and my plan sponsor includes their agents and service providers.

I authorize Sun Life and Homewood Health to collect, use and disclose relevant information about my job and my medical condition needed to assess and administer my accommodation request with:

- health professionals,
- my plan sponsor's occupational health services team, if applicable,
- my plan sponsor (excluding information about my diagnosis and treatment, unless it's already in my plan sponsor's file).

For disputes

I authorize Sun Life, Homewood Health, my plan sponsor and their occupational health services team to collect, use and disclose among them relevant information, including details about my diagnosis and treatment to respond to or resolve:

- a demand or dispute with or against my plan sponsor in which I have threatened to:
  - sue my plan sponsor or
  - file a grievance or other formal complaint before a board, tribunal or court;
- a legal proceeding, which includes a civil proceeding, arbitration or human rights complaint, about my request.

Conditions of consent:

- My consent is valid for the duration of:
  - my accommodation request,
  - any dispute related to this request or my accommodation,
  - for audit purposes, the contract between Sun Life and my plan sponsor.
- I understand that I can withdraw this authorization at any time during my accommodation request. I understand that if I withdraw this authorization:
  - Sun Life and Homewood Health will no longer be able to assess my accommodation request and,
  - Sun Life and Homewood Health will close my file.

In place of my handwritten signature, I have typed my name. Both my typed name and an electronic copy of this form are as valid as an original.

Plan member last name (please print)	First name (please print)	
Signature X		Date (dd-mm-yyyy)

Respecting your privacy

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