Disability claim – Claimant's statement

Sun Life Financial

To avoid any delays in the assessment of this claim, the Employer's statement and the Attending physician's statement of disability must be submitted. **Any cost for information to support your claim will be the policy owner's responsibility.**

1 Your information

Policy number	Provincial health insurance plan number	Date of birth (dd-mm-yyyy)

First name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	Gender ☐ Male ☐ Female

Address (street number and name)	Apartment or suite

City	Province	Postal code	Daytime telephone number

2 Your employer information

Name	

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number

3 Your medical condition

Do not tell us about genetic testing or genetic testing results.

Date your medical condition first prevented you from working (dd-mm-yyyy)	Date you first suffered symptoms of your illness (dd-mm-yyyy)

Describe your present medical condition, its cause and history. If you were injured, also describe the accident, including when and where it took place.

Have you **ever** had a similar injury or illness in the past? ☐ Yes ☐ No If '***yes***', describe your condition, the original date of illness or injury, and any time lost from work.

3 Your medical condition (continued)

List all physicians you have seen for your past and present medical condition(s) over the **last 8 years** (attach copies of all available physician/medical reports).

Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number
Physician's first name	Last name	Dates seen (dd-mm-yyyy) to
Address		Telephone number

4 Your education and training

What was the highest grade level you completed or the highest degree you obtained?	Country where education completed
Language — English ☐ Written ☐ Spoken; French ☐ Written ☐ Spoken; Other: ______ ☐ Written ☐ Spoken	
Name technical or administrative courses taken	
Name apprenticeships completed	
Indicate your computer knowledge ☐ none ☐ home use only ☐ intermediate ☐ expert	If you have a valid driver's license, indicate the class(es) ☐ standard ☐ motorcycle ☐ truck ☐ bus ☐ other ______

5 Your work experience

Present employment

Your present occupation (job title)	Date you started (dd-mm-yyyy)
Briefly describe your duties	

5 Your work experience (continued)

Past employment: Complete the following, providing details of your previous positions.

Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to
Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to
Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to
Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to
Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to
Name of employer	Job title and duties	Duration of employment (dd-mm-yyyy) to

Job skills acquired in your current and previous jobs (e.g. operation of equipment, supervisory skills, etc...). Where appropriate, give level of proficiency.

6 Returning to work

Have you, or did you, attempt to return to work? ☐ Yes ☐ No	If '***yes***', provide dates (dd-mm-yyyy) From to	Indicate: ☐ Full time or ☐ Part time ☐ Usual job or ☐ New job/duties

If '***no***', when do you expect to return to your own occupation? (dd-mm-yyyy) or return to any other occupation? (dd-mm-yyyy)

Are you currently involved in a rehabilitation/training program? ☐ Yes ☐ No If '***yes***', provide details.

7 Your other income

If you are currently receiving or expect to receive money from the sources listed below, provide all requested details below.
We may take some of these amounts into consideration when we calculate your benefit.

Source	Have you claimed for this benefit?	If 'yes', are you receiving this benefit?	If 'yes', provide details below. Amount	Frequency	Effective date (dd-mm-yyyy)	Claim number
Provincial disability insurance (i.e. WCB/WHSCC/CSST/WSIB)	☐ Yes ☐ No	☐ Yes ☐ No	$			
Government disability pension plan (i.e. CPP/RRQ)	☐ Yes ☐ No	☐ Yes ☐ No	$			
Auto insurance	☐ Yes ☐ No	☐ Yes ☐ No	$			
Other (eg: disability income from a personal policy, loan payment protection insurance)	☐ Yes ☐ No	☐ Yes ☐ No	$			
Group benefits (i.e. Short term disability/ Long term disability)	☐ Yes ☐ No	☐ Yes ☐ No	$			
	Company name					Claim number

8 Your declaration and authorization

I certify the above answers are, complete and true. I authorize any licensed physician, medical practitioner or health care professional who has observed me for diagnosis or treatment, any hospital, clinic or other medically related facility where I have been a patient, any public body, or any private health or social services establishment to release to Sun Life Assurance Company of Canada (Sun Life Financial) information needed to adjudicate and administer this claim. I authorize Sun Life Financial, its advisors and service providers to collect, use and exchange information needed for adjudicating and administering this claim with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans, institutions, investigative agencies, insurers and reinsurers when Sun Life Financial deems it necessary for the purpose of adjudicating and administering this claim.

I understand this authorization is valid for the duration of this claim.

Date (dd-mm-yyyy)	Insured person's signature or attorney's signature (authorized under a power of attorney for property)
	X

A copy of this authorization is as valid as the original.

Power of attorney for property (please attach a copy of the power of attorney for property document)

Name of attorney		Relationship
Address (street number and name)		Apartment or suite
City	Province	Postal code
Home telephone number	Work telephone number	

Please return this form to:

Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo
Waterloo, ON N2J 4C5

If you prefer, you can fax this form to the number below. If you do, please keep a copy for your future reference.

Fax number: 1-866-487-4745

Important information you should know

Important: Ensure you leave this page with the claimant.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial 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*.