Disability claim – Attending physician's statement of disability

Sun Life Financial

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

1 Personal information – This section only is to be completed by the patient

You are responsible for obtaining this form and any charges for its completion, unless prohibited by law.

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

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

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.

Signature of patient	Date (dd-mm-yyyy)
X	

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

2 Physician information – Sections 2 - 3 are to be completed by attending physician.

First name of physician completing this form	Last name	
☐ Family doctor ☐ Specialist (indicate specialty): _____		
Address (street number and name)		Suite
City	Province	Postal code
Telephone number	Fax number	

3 Medical information

The Individual Claims department will use the information to assess your patient's eligibility for disability benefits. Eligibility assessed according to the contract definition of "disability", which may change at a specified date. According to the contract, disability has two definitions:

Own occupation: **Unable to perform the essential duties of the occupation in which the patient participated just before the disability started.**

Any occupation: **Unable to perform the essential duties of any occupation based on the patient's education, training and work experience.**

We may disclose any information provided by you to Sun Life Assurance Company of Canada about this claim to the patient and/or those authorized by them to receive such disclosure unless you notify us 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.

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3 Medical information (continued)

To ensure the prompt adjudication of your patient's claim, the following information may assist you as you complete this form:

- To qualify for benefits, there must be clinical findings supporting disability – identify specific signs and symptoms.
- Provide specific details of any functional limitations which prevent your patient from performing the essential duties of her/his own occupation or any other occupation including the severity of the functional limitation.
- Include any additional information supporting disability that will facilitate the assessment of the claim including:
  - A summary of specialists' findings.
  - Investigative test results.
  - Consultation reports.
  - **Do not tell us about genetic testing or genetic test results.**
- Complete form promptly.

Sun Life Assurance Company of Canada thanks you for your assistance. If you have additional questions, please contact our office at **1-877-786-5433.**

The policy owner is responsible for the costs of obtaining medical evidence and the completion of this form, unless prohibited by law.

The following information will be used to assess your patient's eligibility for disability benefits. Full and accurate answers expedite adjudication.

Diagnosis

Primary diagnosis	
Symptoms	
Secondary diagnosis	
Symptoms	
Other contributing factors/complications	Is condition considered chronic? ☐ Yes ☐ No

History

Symptoms began or accident happened on (dd-mm-yyyy)	Illness or injury forced cessation of work on (dd-mm-yyyy)	First visit (dd-mm-yyyy)

Is this a work-related illness/injury? ☐ Yes ☐ No ☐ Unknown	Has the patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown If '**yes**', state when and describe condition:

In the **last 8 years**, please provide details of any illness or injury for a period **exceeding 2 weeks** for which you have treated the patient.

Has the patient, to your knowledge, used any form of tobacco or nicotine products? ☐ Yes ☐ No If '**yes**', please provide details.

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3 Medical information (continued)

Clinical findings/investigations

Most recent examination of patient	The patient is ☐ Right handed ☐ Left handed	Height	Weight	Blood pressure	Pulse

Investigations (e.g., EKGs, x-rays, lab tests, etc.)	Date performed (dd-mm-yyyy)	Summary of results
		Copies attached ☐ Yes ☐ No
		Copies attached ☐ Yes ☐ No
		Copies attached ☐ Yes ☐ No

Are any further investigations planned? ☐ Yes ☐ No If '**yes**', indicate when and type of investigation.

Has the patient been referred to any other physician(s)/specialist(s)? ☐ Yes ☐ No If '**yes**', complete the following chart.

Physician's name and specialty	Date of examination (dd-mm-yyyy)	Findings

Was the patient hospitalized? ☐ Yes ☐ No If '**yes**', provide the institution's name.	Date of admission (dd-mm-yyyy)	Date of discharge (dd-mm-yyyy)

Treatment

I see this patient:
☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (specify): _____

List current medications prescribed and dosage

Therapy? ☐ Yes ☐ No If '**yes**', indicate type (e.g. physiotherapy, psychotherapy, etc.).

Therapy frequency	Therapy at:
☐ Daily ☐ _____ x per week ☐ Other: _____	☐ Outpatient dept. ☐ Clinic ☐ Home
Surgery? ☐ Yes ☐ No If '**yes**', type of surgery.	Date (dd-mm-yyyy) ☐ performed ☐ planned

Any other treatment or future plans for treatment? ☐ Yes ☐ No If '**yes**', specify with dates.

Summarize the patient's response to treatment

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3 Medical information (continued)

Functional limitations during the disability period

Function		Degree of limitation/severity					Required information	
		None	Slight	Moderate	Severe	Don't know		
Psychological		☐	☐	☐	☐	☐	Current GAF score ☐ Less than 40 ☐ 61-70 (mild symptoms) ☐ 41-50 (serious symptoms) ☐ greater than 71 ☐ 51-60 (moderate symptoms)	
Sensory and neurological	Cognition	☐	☐	☐	☐	☐		
	Speaking	☐	☐	☐	☐	☐		
	Hearing	☐	☐	☐	☐	☐		
	Vision	☐	☐	☐	☐	☐	Corrected visual acuity Left: Right:	
	Sensation	☐	☐	☐	☐	☐		
	Dexterity	☐	☐	☐	☐	☐		
Physical	Driving	☐	☐	☐	☐	☐	Time restriction:	
	Walking	☐	☐	☐	☐	☐	Time restriction:	
	Standing	☐	☐	☐	☐	☐	Time restriction:	
	Climbing	☐	☐	☐	☐	☐		
	Sitting	☐	☐	☐	☐	☐	Time restriction:	
	Bending	☐	☐	☐	☐	☐		
	Lifting	☐	☐	☐	☐	☐	Maximum recommended weight:	
Cardiac	Condition	None	Mild	Moderate	Severe	Don't know	Treatment	Response
	Cardiomegaly	☐	☐	☐	☐	☐		
	Congestive heart failure	☐	☐	☐	☐	☐		
	Hypertension	☐	☐	☐	☐	☐		
	Angina	☐	☐	☐	☐	☐		
	Shortness of breath	☐	☐	☐	☐	☐		
	Palpitations	☐	☐	☐	☐	☐		
	Edema	☐	☐	☐	☐	☐		
	Cardiac class: ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)							

For injuries affecting movement, please list limitations affecting ROM.

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Describe any additional functional limitations, physical or psychological, which you consider to be major obstacles to the patient's ability to work.

Were any functional evaluations performed? ☐ Yes ☐ No If '**yes**', attach copy or provide details.

Has or will the patient be referred to a medical rehabilitation program? ☐ Yes ☐ No If '**yes**', give details.

Prognosis

Is patient currently working?	☐ Yes	Since what date (dd-mm-yyyy)?	☐ the patient returned to their own occupation ☐ the patient returned to an alternate occupation	☐ full time ☐ part time ☐ progressive return (please provide details below)
	☐ No	In your opinion, the patient is/will be capable of returning to work on what date (dd-mm-yyyy)?	☐ the patient is/will be capable of returning to their own occupation ☐ the patient is/will be capable of returning to an alternate occupation The alternate occupation is: ☐ sedentary ☐ light ☐ medium ☐ heavy occupation	☐ full time ☐ part time ☐ progressive return (please provide details below)

Any other comments or progressive return to work plan

Please print physician's name

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

Please return this form to the patient or 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