

# Disability claim – Attending physician’s statement of disability

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 <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 X	Date (dd-mm-yyyy)
---------------------------	-------------------

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	
<input type="checkbox"/> Family doctor <input type="checkbox"/> 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.

# Disability claim – Attending physician’s statement of disability

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has the patient ever had the same or a similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If 'yes', state when and describe condition: _____	
In the <b>last 8 years</b> , please provide details of any illness or injury for a period <b>exceeding 2 weeks</b> for which you have treated the patient.		
Has the patient, to your knowledge, used any form of tobacco or nicotine products? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'yes', please provide details.		

# Disability claim – Attending physician's statement of disability

## 3 Medical information (continued)

### Clinical findings/investigations

Most recent examination of patient	The patient is <input type="checkbox"/> Right handed <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Copies attached <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Copies attached <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are any further investigations planned? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Daily <input type="checkbox"/> _____ x per week <input type="checkbox"/> Other: _____	Therapy at: <input type="checkbox"/> Outpatient dept. <input type="checkbox"/> Clinic <input type="checkbox"/> Home
---	--

Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No    If 'yes', type of surgery.	Date (dd-mm-yyyy) <input type="checkbox"/> performed <input type="checkbox"/> planned
---	---

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


Summarize the patient's response to treatment


# Disability claim – Attending physician’s statement of disability

<b>3</b>	<b>Medical information (continued)</b>
----------	--

**Functional limitations during the disability period**

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

For injuries affecting movement, please list limitations affecting ROM.

# Disability claim – Attending physician's statement of disability

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

Any other comments or progressive return to work plan

Please print physician's name

---

Physician's signature  
X

Date (dd-mm-yyyy)

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