Disability claim – Employer's statement

Sun Life Financial

To avoid any delays in the assessment of this claim, the Claimant's statement and the Attending physician's statement of disability must be submitted. **This form should be fully completed.**

1 Employee personal information – This section only is to be completed by the employee

Policy number	First name of employee ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	Gender ☐ Male ☐ Female

2 Employer information – Sections 2 - 6 are to be completed by the employer

Name of company			
Address (street number and name)		Suite	City
Province	Postal code	Telephone number	

3 Eligibility information

Date employed (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Number of hours worked in a regular week:	Has employee returned to work? ☐ No ☐ Yes If yes, date returned work: (dd-mm-yyyy)
			If no, date expected to return: (dd-mm-yyyy)

Reason employee stopped work:

☐ Work related disability ☐ Other disability ☐ Leave of absence ☐ Laid off ☐ Other

4 Benefits

Group disability provider (Insurance company name):				
Group disability benefits policy number:	Disability claim effective date: (dd-mm-yyyy)	Disability claim status ☐ Pending ☐ Approved ☐ Declined ☐ Appeal ☐ Other:	If approved, since when: (dd-mm-yyyy)	Disability benefit amount $
Workers Compensation Benefits claim number:	Benefit claim ffective date: (dd-mm-yyyy)	Benefits claim status ☐ Pending ☐ Approved ☐ Declined ☐ Appeal ☐ Other:	If approved, since when: (dd-mm-yyyy)	Benefit amount $

5 Attendance information

During the last 3 years, has any illness or injury prevented the employee from performing his/her normal duties at his/her usual occupation for a period exceeding 2 weeks? If yes, please complete section below:

First disability date (dd-mm-yyyy)	Reasons	Return to work date (dd-mm-yyyy)

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6 Occupation

Job Title

Please answer the following questions or attach a formal job description. The information should be about the employee's usual job duties immediately before he/she stopped working.

Position held		
Minimum educational requirements		
Training courses/certificate(s) required		
Briefly describe this employee's usual job duties		
Number of hours spent each day walking:	Number of hours spent each day standing:	Number of hours spent each day sitting:

Does the job require	
Using machinery or special equipment	☐ No ☐ Yes If yes, specify
Lifting or carrying	☐ No ☐ Yes If yes, state: Approximate weight to be lifted or carried _____ from height of _____ to height of _____ How often is lifting or carrying required? _____
Reaching or bending	☐ No ☐ Yes If yes, describe tasks and frequency
Climbing	☐ No ☐ Yes If yes, describe type of climbing (e.g. stairs, ladders, poles) How often is climbing required? _____
Using a computer	☐ No ☐ Yes If yes, how many hours spent each day
	Are there any unusual physical requirements to this job? ☐ No ☐ Yes If yes, describe
	Does the job present unusual work environment/working conditions (e.g. working above or below ground level, heat, cold, dampness, dust, gases, hazards)? ☐ No ☐ Yes If yes, describe
	Provide any other information about the employee that would impact their ability to work

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Contact person's name	Last name	Telephone number
		– –
Position/Title		
Signature X		Date (dd-mm-yyyy) – –

Please return this form to the employee 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