Sun Life Financial
227 King St South
P.O Box 1601, STN Waterloo
Waterloo ON N2J 4C5

Fax: 1-866-255-5825
Email: DISABLE@sunlife.com

Dear Cardiologist

Thank you for completing this form on behalf of your patient and our Insured. Your patient has critical illness insurance coverage with Sun Life Financial and has requested forms to file a claim for that benefit under the policy.

Critical illness insurance covers a number of medical conditions each with a specific set of diagnostic criteria. We require answers to the questions on the attached form to assist us with our adjudication of your patient's claim.

Your patient is claiming under the heart attack definition of the policy. In addition to completing the form, providing as much level of detail as is possible, please also provide us with the following:

- Copies of any specialist or hospital reports.
- Hospital admission and discharge summaries.
- Copies of any ECG, cardiac enzymes results or blood tests, angiograms, echocardiograms and imaging studies together with any other tests, readings, or similar evidence.

Notes:

- **Do not tell us about genetic testing or genetic testing results.**
- **To qualify for this benefit your patient must have had a heart attack which resulted in a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least 1 of the following:**
  - **Heart attack symptoms.**
  - **New electrocardiogram (ECG) changes consistent with a heart attack.**
  - **Development of new Q Waves during or immediately following an intra-arterial cardiac procedures including, but not limited to, coronary angiography and coronary angioplasty.**

We would be pleased to pay a $50.00 administrative fee for photocopying upon receipt of your patient's records. Please attach your invoice to this form. If there is a charge for completion of the form, it is the responsibility of your patient to pay this.

Thank you for your assistance. If you have any questions please call 1-877-786-5433, ext. 441-2809 or e-mail us at DISABLE@sunlife.com.

Important: Do not return this page with the completed form.

Critical Illness Insurance – Physician's statement – Heart attack

Sun Life Financial

Policy number

The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.

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

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Gender ☐ Male ☐ Female
Provincial health insurance plan number		Date of birth (dd-mm-yyyy)	
Address (street number and name)	Apartment	City	
Province	Postal code	Daytime telephone number	

Authorization

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 about 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)	Signature of patient X

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

2 Patient information – to be completed by treating cardiologist

In addition to answering the following questions, ensure you provide us with copies of any specialist or hospital reports, including Admission and Discharge summaries, copies of any ECG, cardiac enzyme results or blood tests, angiograms, echocardiograms and imaging studies, together with any other tests, readings, or similar evidence in support of your patient's claim. Do not tell us about genetic testing or genetic testing results.

2.1 Was a diagnosis of heart attack made? ..... ☐ Yes ☐ No

If '**yes**', when was the diagnosis made? Date (dd-mm-yyyy)

2.2 If '**yes**' to 2.1, provide description and date of onset of clinical signs and symptoms which support the diagnosis of heart attack. Date (dd-mm-yyyy)

2 Patient information (continued)

2.3 Was there a rise and fall of biochemical cardiac markers diagnostic of a heart attack? ☐ Yes ☐ No
If '**yes**', provide cardiac enzyme levels and/or troponin including CPK-MB fraction and percentage of total CPK at time of diagnosis of your patient's heart attack. Ensure you provide copies of all reports.

2.4 a) Were there ECG changes to support the diagnosis of heart attack at the time of the event? ☐ Yes ☐ No
b) Were Q waves identified during or immediately following an intra-arterial procedure? ☐ Yes ☐ No
If '**yes**' to a) or b), ensure you provide copies of all reports and tracings.

2.5 Did angiogram, echocardiogram or other imaging studies support the diagnosis of a heart attack or show evidence of a recent coronary artery blockage? ☐ Yes ☐ No
If '**yes**', provide details below and ensure you provide copies of all tests performed.

2.6 Have any other investigations been performed? ☐ Yes ☐ No
If '**yes**', provide details below and ensure you provide copies of all tests performed.

Date (dd-mm-yyyy)	Details

2.7 Provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any other related condition.

Physician/hospital name	Address	Date (dd-mm-yyyy)	Reason for visit

2.8 Has your patient had any prior history of heart problems? ☐ Yes ☐ No
If '**yes**', provide details below.

Date (dd-mm-yyyy)	Details

2.9 Has the heart attack been caused by any substance abuse? ☐ Yes ☐ No
If '**yes**', provide details.

2.10 Have any of your patient's biological parents, brothers or sisters been diagnosed **before age 65** with heart disease? ☐ Yes ☐ No
If '**yes**', provide details including age and year of diagnosis.

2 Patient information (continued)

2.11 Does your patient smoke? ..... ☐ Yes ☐ No If '**no**', has your patient ever smoked? ..... ☐ Yes ☐ No
If '**yes**', provide details of smoking history.

2.12 Provide any other information that would be helpful in the assessment of your patient's claim.

Ensure you provide us with copies of any specialist or hospital reports, including Admission and Discharge summaries, copies of any ECG, cardiac enzyme results or blood tests, angiograms, echocardiograms and imaging studies, together with any other tests, readings, or similar evidence in support of your patient's claim. Do not tell us about genetic testing or genetic testing results.

3 Physician's authorization and signature

Any information provided by you to Sun Life Financial about this claim may be disclosed 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.

Physician's last name (please print)	First name		Speciality
Address (street number and name)			Suite
City	Province	Postal code	Telephone number
Date (dd-mm-yyyy)	Physician's signature X		

Please send the completed original form to:

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

You can fax this form to fax number 1-866-487-4745. If you do, please keep a copy for your future reference and ensure the original form is sent to the address above.