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 Neurologist

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 stroke 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:

- Both hospital admission and discharge summaries.
- All specialist and rehabilitation reports.
- All CT scans and MRI reports.
- Any other test results or similar evidence in support of your patient's diagnosis.
- Documentation of all new and ongoing neurological deficits.

Notes:

- **Do not tell us about genetic testing or genetic testing results.**
- **To qualify for this benefit your patient must have new neurological deficits that persist for at least 30 days.**
- **Please refrain from completing this form until it is evident that this will happen.**

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 – Stroke/ Cerebrovascular Accident (CVA)

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 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)	Signature of patient
	X

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

2 Physician information – Complete only if your patient's neurological deficits last for **> 30 days**.

Ensure you enclose the following with this form:

- Both hospital admission and discharge summaries.
- All specialist reports.
- All CT scans and MRI reports.
- Any other test results or similar evidence in support of your patient's diagnosis. **Do not tell us about genetic testing or genetic testing results.**
- Documentation of all ongoing neurological deficits.

Notes:

- Ensure you refrain from completing this form until it's evident that your patient has or will have neurological deficits lasting for **more than 30 days**.
- The patient is responsible for the cost of completing this form.

Date of CVA (dd-mm-yyyy)	Was a diagnosis of a CVA made? ☐ Yes ☐ No	First name of physician that provided diagnosis	Last name
Was the CVA or stroke caused by an infarction of brain tissue, hemorrhage, embolism or aneurysm? ☐ Yes ☐ No If '**yes**', provide details.			

2 Physician information – Complete only if your patient's neurological deficits last for **> 30 days**. (continued)

Date patient first suffered symptoms or episodes of cerebrovascular disease (dd-mm-yyyy)	Provide details describing those symptoms/episodes.	
Date patient first consulted you for their condition (dd-mm-yyyy)	Date patient first consulted a physician for their condition (dd-mm-yyyy)	Date patient first became aware of their diagnosis (dd-mm-yyyy)

Are there residual new objective neurological deficits? ☐ Yes ☐ No

If '**yes**', provide details of all new objective neurological deficits present 30 days following the CVA.

Prior to the CVA, were there any pre-existing neurological deficits? ☐ Yes ☐ No

If '**yes**', provide details describing the deficit, cause and date of onset.

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**

Are you aware if your patient's father, mother, brothers or sisters have **ever** suffered from this or any other related condition? ☐ Yes ☐ No

If '**yes**', provide details below.

Name	**Relationship to patient**	**Age at onset**	**Year of diagnosis**

Does your patient smoke? ☐ Yes ☐ No If '**no**', has your patient **ever** smoked? ☐ Yes ☐ No

If '**yes**', provide details of smoking history.

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

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.