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 coronary artery bypass surgery 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 pre-operative and operative reports, together with any other tests, readings, or similar evidence in support of your patient's claim.

Notes:

- **Do not tell us about genetic testing or genetic testing results.**
- **To qualify for this benefit, coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).**
- **The surgery must be determined to be medically necessary by a specialist.**

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 – Coronary Artery Bypass Surgery

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 – to be completed by attending physician

Has your patient had heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts? ☐ Yes ☐ No

Name and address of the cardiologist recommending surgery

Name of cardiologist	Address
Date surgery took place (dd-mm-yyyy)	Where did the surgery take place?
Provide details of the bypass surgery and provide a copy of the operative report	

Date patient first suffered symptoms (dd-mm-yyyy)	Date patient first became aware of their condition (dd-mm-yyyy)
Date patient first consulted you for their condition (dd-mm-yyyy)	Date patient first consulted a physician for their condition (dd-mm-yyyy)

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

Physician/hospital name	Address

2 Physician information (continued)

Has your patient had any prior history of heart problems or had any previous episodes of the underlying condition? ☐ Yes ☐ No
If '**yes**', provide details below. **Do not tell us about genetic testing or genetic testing results**.

What investigations, tests or procedures were performed prior to surgery? Provide details and copies of any pre-operative angiography findings.

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 including age and year of diagnosis.

Relationship	Name of condition	Year diagnosed	Age at 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.

Ensure you provide us with copies of any specialist or hospital reports, including copies of any pre-operative and operative reports, 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.

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