Long Term Care Insurance

Advisor information sheet – do not give to claimant

What you need to do before the claim form is provided to claimant:

You must review the eligibility requirements including waiting and filing periods with the insured person or their attorney authorized under a power of attorney for property.

Eligibility requirements include:

1. Physical dependency and deteriorated mental ability

To be eligible for long term care insurance benefits the insured person must:

- always need substantial physical or stand-by assistance from another person to perform **two or more** of the activities of daily living (refer to question #11 for a list and description of the activities of daily living), and/or
- need continual supervision by another person for protection from harm to their physical health and safety as the result of mental deterioration due to an organic brain disorder such as Alzheimer's disease, irreversible dementia or brain injury.

2. Waiting period and filing period

The waiting period must be satisfied **before** the physician completes the Attending physician statement (form #E222).

If the claim is submitted outside of the filing period then the claimant must provide a written explanation to us explaining why the claim is late.

If you have any questions, you can reach the Individual Insurance Claims department by calling the toll free advisor line.

This page is for your use only – do not give it to the claimant.

Long Term Care Insurance – Claimant's statement

Policy Number

PLEASE PRINT

Instructions

This claimant's statement is to be used to apply for long term care insurance benefits. It must be completed and signed by:

- the insured person, or
- the attorney authorized under a power of attorney for property, if the insured person is incompetent and/or incapacitated. Complete the power of attorney on page 5 and provide a copy of the power of attorney for property document.

The policyholder is responsible for the costs of obtaining medical information.

1 Personal information

☐ 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	

1. If you have a spouse, they may qualify for a spousal waiver benefit if they own a long term care insurance policy with Sun Life Assurance Company of Canada. Provide the long term care insurance policy number.

   Policy number

2. Are you currently living at the address listed above? ☐ Yes ☐ No

   'If '**yes**', who do you live with? ☐ Alone ☐ With spouse ☐ With family member

   ☐ Other (specify) ______________________

   If '**no**' currently at: ☐ Nursing home ☐ Hospital ☐ Home of family member

   ☐ Other (specify) ______________________

   Telephone number where you can be reached: Telephone number

2 Physical dependency information

Do not tell us about genetic testing or genetic testing results.

3. **Physical dependency:**

   a) Describe your physical dependency.

   b) Diagnosis

   c) Date you first required assistance for **2 or more** activities of daily living. See page 4 for description of activities of daily living

   Date (dd-mm-yyyy)

   d) If your dependency has ended, indicate the date you no longer required assistance.

   Date (dd-mm-yyyy)

   e) Attach a copy of all medical reports you have in your possession related to your physical dependency.

4. If your dependency was the result of an accident, provide details. If you were operating a vehicle, enclose a copy of the police accident report.

5. Are you receiving benefits from the auto insurer? ☐ Yes ☐ No

   If '**yes**', provide the auto insurer and your claim number.

Auto insurer	Claim number

6. **Cognitive impairment:**

   a) Date continual supervision was first required.

   Date (dd-mm-yyyy)

   b) Diagnosis

2 Physical dependency information (continued)

7. List the name of all physicians and medical clinics that have provided medical assessments and/or care over the **last 7 years**.

First name	Last name	Telephone number	Dates seen (dd-mm-yyyy)	
			From	To
			From	To
			From	To
			From	To
			From	To
			From	To
			From	To
			From	To

8. If you have been in a hospital or nursing facility for your present medical condition, provide the information requested below:

Name of hospital/facility	Telephone number	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)

9. List all caregivers who currently provide support. Include licensed caregivers as well as friends and family members who have been providing assistance.

Name of agency/person providing care	Relationship of person providing care	Telephone number	Dates of service (dd-mm-yyyy)	Description of assistance provided
			From To	
			From To	
			From To	
			From To	

10. Do you use assistive devices to perform any of your activities of daily living? ☐ Yes ☐ No

If '**yes**', indicate all that apply.

☐ adjustable bed ☐ buttonhook ☐ cane ☐ crutches ☐ grab bars ☐ transfer bench ☐ walker
☐ wheelchair ☐ reacher ☐ bath stool ☐ long handled bath brush ☐ seat lift
☐ raised toilet seat
☐ other (specify) ______________________

2 Physical dependency information (continued)

11. Do you need substantial physical assistance or stand-by assistance from another person to safely and completely perform 2 or more of the activities of daily living as described below? Stand-by assistance means the other person must be within arm's reach of the insured person each time the relevant activity of daily living is performed. Complete this section as the information required is essential to our review of your claim.

Activities of daily living	Assistance required	Dates assistance was required (dd-mm-yyyy)	Details (Describe type and frequency of assistance)
Bathing (washing oneself) a) by sponge bath b) in the tub or shower c) getting in and out of the tub or shower	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	From To	
Dressing (to put on, take off, fasten and unfasten) a) clothing b) medically necessary braces or artificial limbs	 ☐ Yes ☐ No ☐ Yes ☐ No	From To	
Feeding (feeding oneself by getting food into the body, NOT including cooking or preparing a meal) a) through the mouth b) by feeding tube c) intravenously	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	From To	
Toileting a) getting to and from the toilet b) getting on and off the toilet c) performing associated personal hygiene	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	From To	
Transferring (moving to or from a bed or chair) a) moving into or out of a bed b) moving into or out of a chair c) moving into or out of a wheelchair	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	From To	
Continence a) are you able to control your bladder function? b) are you able to control your bowel function? c) do you need help performing associated personal hygiene? d) do you have a catheter or colostomy bag? e) do you need help caring for your catheter or colostomy bag?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	From To	

3 Certification and authorization (to be completed by the insured person)

I certify the above answers are, complete and true. 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 and the policy 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 purposes of adjudicating and administering this claim and the policy.

I understand this certification and authorization is valid for the duration of this claim.

Date (dd-mm-yyyy)	Insured person's signature or attorney's signature (authorized under a power of attorney for property)
	X

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

Power of attorney for property (include copy of document)

Name of attorney		Relationship
Address (street number and name)		Suite/apartment number
City	Province	Postal code

Home telephone number	Work telephone number

Please keep a copy and return the original 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, keep the form for your future reference.

Fax number: 1-866-487-4745

© Sun Life Assurance Company of Canada, 2017.

Important information you should know

Sun Life Financial

Important: Ensure you leave this page with the claimant.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.