Long term care insurance – Attending physician's statement

Sun Life Financial

Policy number

PLEASE PRINT

1 Personal information – Sections 1 and 2 are to be completed by the patient (insured person)

Please complete the first page and then give the form to your physician to complete the remaining pages.
The patient is responsible for obtaining this form and any charges for its completion.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Last name	First name
Provincial health insurance plan number	
Date you first required assistance for 2 or more activities of daily living. For a description of activities of daily living please refer to your contract. **Note: This date should be the same as the date you stated on your claimant's statement.**	(dd-mm-yyyy)

2 Authorization

The insured person (or their attorney if authorized under a power of attorney) authorizes:

- any physician, medical practitioner or health care professional who has observed the insured person for diagnosis or treatment, any hospital, clinic or other medically related facility where the insured person has been a patient, any public body, or any private health or social services establishment to release to Sun Life Financial information needed to adjudicate and administer this claim, and
- 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.

The insured person (or their attorney if authorized under a power of attorney) understands and agrees that this authorization is valid for the duration of this claim.

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

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

Last name of physician completing this form	First name	
☐ Family doctor ☐ Specialist (indicate specialty)		
Address (street number and name)		Apartment or suite
City	Province	Postal code
Telephone number	Fax number	

PLEASE PRINT

3 Medical information – Section 3 is to be completed by the attending physician

The following information will be used to assess your patient's eligibility under a long term care insurance policy, based on the inability to do activities of daily living or the presence of a cognitive impairment. Full and accurate answers allow us to assess the claim more quickly. Please mail this form to the address provided at the bottom of page 5.

Note: A claim cannot be considered without a copy of ALL consultation reports, test results and clinical notes since the date of activity of daily living dependency or cognitive impairment. Please also include a copy of any hospital admission and/or discharge reports. Do not tell us about genetic testing or genetic test results.

Diagnosis

1. Primary	Symptoms
2. Secondary	Symptoms

History

1. Symptoms began on: Date (dd-mm-yyyy)

2. a) When was the first visit for the diagnosed condition? Date (dd-mm-yyyy)

   b) What was the nature of the visit (chief complaint)?

3. a) Has your patient had the same or similar conditions in the past? ☐ Yes ☐ No ☐ Unknown

   b) If '**yes**', provide details.

4. a) When was the last time you saw your patient? Date (dd-mm-yyyy)

   b) What was the nature of the visit the last time you saw your patient (chief complaint)?

5. Provide details of any significant or chronic illness that your patient has been treated for, the date of diagnosis and any signs or symptoms.

6. a) Has there been a concern about alcohol/drug abuse? ☐ Yes ☐ No ☐ Unknown

   b) If '**yes**', state when and describe condition.

7. Is patient ☐ right-handed? ☐ left-handed?

3 Medical information – Section 3 is to be completed by the attending physician (continued)

8. Describe your patient's functional limitations related to balance and dexterity. Also give specific range of motion for back, neck, shoulders, hips and knees as determined by your examination.

9. Have any functional evaluations been performed? ☐ Yes ☐ No If '**yes**', attach copies.

10. Has or will the patient be referred to a medical rehabilitation program or for physiotherapy? ☐ Yes ☐ No
If '**yes**', provide details.

DETERIORATED MENTAL ABILITY (To be completed for a cognitive impairment claim; otherwise, go to question 12)

Cognitive impairment in our contract is defined as deteriorated mental ability resulting from organic brain disease such as Alzheimer's disease, irreversible dementia or brain injury. It is established using clinical evidence and standard tests. Do not tell us about genetic testing or genetic test results.

11. a) What is the diagnosis?

Diagnosis	Date (dd-mm-yyyy)
Date of most recent Mini Mental State Examination (MMSE) (dd-mm-yyyy)	Score

b) Choose the option that best describes your patient's current level of cognitive impairment:

☐ Patient has mild to moderate cognitive impairment
☐ Patient has severe cognitive impairment

c) Has your patient's driver's licence been revoked? ☐ Yes ☐ No If '**yes**', provide date. (dd-mm-yyyy)

d) If you have any additional information describing your patient's cognitive status, provide your comments.

e) Has your patient been admitted to a long-term care facility since becoming cognitively impaired? ☐ Yes ☐ No
If '**yes**', provide the information requested below.

Facility name	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)
Facility name	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)

3 Medical information – Section 3 is to be completed by the attending physician (continued)

Treatment

Complete the treatment section regardless of whether the claim is for activity of daily living dependency or cognitive impairment.

12. I see this patient: ☐ Weekly ☐ Bi-weekly ☐ Other (specify) ☐ Monthly

13. List current medications prescribed and dosage.

14. Investigations performed (eg EKG's, x-rays, lab tests etc.)

Name	Date performed (dd-mm-yyyy)	Summary of results (Attach copies of all available reports)
Name	Date performed (dd-mm-yyyy)	Summary of results (Attach copies of all available reports)

15. Are any further investigations planned? ☐ Yes ☐ No

If '**yes**', state type and when.

16. Has your patient been admitted to a hospital or nursing facility? ☐ Yes ☐ No
If '**yes**', provide the information requested below. Include documentation such as admission report and/or discharge report.

Facility name	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)
Facility name	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)

17. Has your patient had surgery or is any planned? ☐ Yes ☐ No If '**yes**', provide details.

Type of surgery	Date (dd-mm-yyyy)

18. Has your patient been referred to any other physicians/specialists? ☐ Yes ☐ No If '**yes**', provide details.

Physician's name	Specialty
Date of examination (dd-mm-yyyy)	Findings

Physician's name	Specialty
Date of examination (dd-mm-yyyy)	Findings

19. Has your patient had therapy, is currently in therapy or is any planned? ☐ Yes ☐ No
If '**yes**', indicate the type of therapy (eg. physiotherapy, psychotherapy, etc.).

Frequency: ☐ Daily ☐ ____ times per week ☐ Other

3 Medical information – Section 3 is to be completed by the attending physician (continued)

20. Is your patient receiving additional treatments such as dressing changes, catheters, ostomy services or IV services?

☐ Yes ☐ No If '**yes**', provide details.

21. Is your patient receiving any other treatment or are there plans for future treatment? ☐ Yes ☐ No

If '**yes**', provide details including dates.

22. Summarize your patient's response to treatment and provide details of any complications, delays in treatment, etc. that may be delaying recovery.

23. **What have you included? (Indicate all that apply.)**

- ☐ all consultation reports
- ☐ test results **(Do not tell us about genetic testing or genetic test results.)**
- ☐ clinical notes since the date of activities of daily living dependency or cognitive impairment
- ☐ hospital admission and/or discharge reports
- ☐ physiotherapy reports or any other reports providing range of motion measurements

24. 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 signature X		
Date (dd-mm-yyyy)	Telephone number	Fax 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, please keep the form for your future reference.

Fax number: 1-866-487-4745

Important information you should know

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*.