



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 Doctor

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 benign brain tumour 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 pathology reports giving detail including the type of tumour, site and histology, 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, benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficits.
- The diagnosis must be made 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 – Benign brain tumour



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

<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last name	First name	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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
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A copy of this authorization is as valid as the original.

2 Physician information – to be completed by attending physician

Indicate the type, size and site of your patient’s tumour. Type: _____ Size: _____ Site: _____		Date patient first suffered symptoms (dd-mm-yyyy)
What were the symptoms?		
Date patient first consulted you for this condition (dd-mm-yyyy)		How long has this person been your patient?
Date this benign tumour was diagnosed (dd-mm-yyyy)		Date patient was advised of this diagnosis (dd-mm-yyyy)
Advised by whom?		

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

Physician/hospital name	Address

2 Physician information – to be completed by attending physician (continued)

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.

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 reports, including copies of pathology reports giving the following details, type of tumour, site and histology, 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.

Policy number