



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](mailto: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 coma 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 Glasgow coma scores covering the period of hospitalization.
- Hospital admission and discharge report.
- Copies of all hospital toxicology reports.

Please also advise us if this coma was medically induced.

**Notes:**

- Do not tell us about genetic testing or genetic testing results.
- To qualify for this benefit your patient must have had a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which the Glasgow coma scale must be 4 or less.
- Please refrain from completing this form until it is evident that this has happened.

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](mailto:DISABLE@sunlife.com).

**Important:** Do not return this page with the completed form.

# Critical Illness Insurance – Physician’s statement – Coma



Policy number
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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

Date you were first consulted for this condition (dd-mm-yyyy)	How long had the symptoms been present?
How long has this person been your patient?	How long was patient in a coma?
Provide details of the underlying cause leading to patient’s coma.	
Provide details, including dates of any predisposing conditions or risk factors that patient has had for coma.	
What tests were performed to determine the depth of the coma?	

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

Provide all Glasgow Coma Scale Scores including the dates and time these readings were obtained and taken.

Glasgow Coma Scale Score	Date (dd-mm-yyyy)	Time
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

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

Does your patient smoke?  Yes  No If 'no', has your patient ever smoked?  Yes  No  
 If 'yes', provide details of smoking history.

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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 any tests, readings or similar evidence in support of your patient's claim. Include all hospital admission and discharge reports. 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
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