Application for access to the policy fund when disabled – Claimant's statement of disability

Sun Life Financial

227 King Street South, PO Box 1601 Stn Waterloo, Waterloo, ON N2J 4C5

Please print clearly in ink

A What you are applying for?

Check one of the following to tell us which benefit you are claiming:

- ☐ Occupationally disabled
- ☐ Critically disabled-accident and sickness
- ☐ Critically disabled-deteriorated mental ability
- ☐ Critically disabled-terminal illness

Note: If you are claiming as critically disabled for accident and sickness or deteriorated mental ability, complete sections A, B and C. Otherwise, only complete sections A and B.

Amount requested to be withdrawn under this benefit (if approved): $ _____ (indicate an amount or maximum amount)

Information you need to know

The claim assessment fee must be paid with the claim. If not paid by cheque, we will withdraw the fee from the policy fund. If you have not attached a cheque, you authorize Sun Life Assurance Company of Canada to withdraw the fee from your policy fund. By signing the authorization statement you authorize us to make the withdrawal from the policy fund.

If you do not qualify for "Access to the policy fund when disabled", any claim assessment fee we withdraw from your policy fund will not be refunded and may result in a taxable disposition.

Signature of owner if different from claimant (insured person)

Note: This authorization should only be completed if the owner and the insured person of the policy are not the same.

If I have not attached a cheque to this claim statement to pay the claim assessment fee, then I authorize Sun Life Assurance Company of Canada to withdraw the fee from my policy fund. I understand that if the insured person does not qualify under the "Access to the policy fund when disabled" that the withdrawal of the fee may result in a taxable disposition.

I consent to Sun Life Assurance Company of Canada's use of my Social Insurance Number for tax-reporting purposes in connection with this claim.

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

Date signed (dd-mm-yyyy)	Signature of owner
	X

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

B Information we need from the insured person to assess the claim

Policy number	Provincial health insurance plan number
First name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name

1.

Date of birth (dd-mm-yyyy)	Language ☐ English ☐ French	Sex ☐ Male ☐ Female	Telephone number	
Address (street number and name)			Apartment or suite	
City			Province	Postal code

Please send only one copy – original or fax toll-free to 1-866-487-4745.

B Information we need from the insured person to assess the claim (continued)

2.

Employer	Your occupation	Telephone number	
Employer's address (street number and name)		Apartment or suite	
City		Province	Postal code

History

1. Describe your present medical condition, its cause and history. (If you were injured, also describe accident, including when and where it took place.)

2. a) Date symptoms began (Date (dd-mm-yyyy)) b) Medical condition has prevented me from working since (Date (dd-mm-yyyy))

   c) Medical condition has forced me to make a change in my employment. ☐ Yes ☐ No

   If '**yes**', indicate income amount prior to change $ _____ and income amount after change $ _____.

3. Have you **ever** had a similar injury or illness in the past? ☐ Yes ☐ No

   If '**yes**', describe your condition, the original date of illness or injury, and any time lost from work.

4. If your condition is the result of an injury, was another party at fault? ☐ Yes ☐ No

   If '**yes**', are you considering, or have you started legal action? ☐ Yes ☐ No

5. List all physicians you have seen for your present medical condition. (Attach copies of all available specialists' reports.)

Physician's name	Address	Dates Seen From	Dates Seen To	Dates of any hospitalizations From	Dates of any hospitalizations To

6. a) Have you attempted to or did you return to work? ☐ Yes ☐ No

   b) If '**yes**', from (Date (dd-mm-yyyy)) to (Date (dd-mm-yyyy)) Indicate: ☐ full-time ☐ part-time ☐ usual job ☐ new job/duties

   c) If '**no**', when do you expect to return to your own occupation (Date (dd-mm-yyyy)) or to any other occupation (Date (dd-mm-yyyy))?

   d) Are you currently involved in a rehab/training program? ☐ Yes ☐ No If '**yes**', provide details.

B Information we need from the insured person to assess the claim (continued)

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

Name	Address and telephone number	Date admitted (dd-mm-yyyy)	Date discharged (dd-mm-yyyy)

8. Are you claiming or receiving any other disability, wage loss, and/or retirement benefits? ☐ Yes ☐ No

If '**yes**', complete this section.

☐ WSIB If '**yes**', complete the WSIB release form on page 7.

Amount _____ Frequency _____ Effective _____ WSIB Claim No. _____

☐ CPP/RPP Disability Pension Amount _____ Frequency _____ Effective _____ Claim No. _____

☐ Car Insurance Amount _____ Frequency _____ Effective _____ Claim No. _____

☐ Group Benefits Amount _____ Frequency _____ Effective _____ Claim No. _____

☐ (STD/LTD) Co. Name _____

☐ Other (e.g. legal action, retirement pension) _____

Education

1. Indicate the highest grade level of education completed: ☐ Grade 6 and under ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

2. a) Name of technical or trade school attended _____ b) Type of diploma obtained _____

3. a) Name of college or university attended _____ b) Number of years completed _____

   c) Type of degree obtained _____ d) Name of major _____

4. Country/province where education completed _____

5. Language a) English ☐ Written ☐ Spoken b) French ☐ Written ☐ Spoken

   c) Other _____ ☐ Written ☐ Spoken

Training

1. Name technical or administrative courses taken _____

2. Name apprenticeships completed _____

3. List any certificates/diplomas/licences you hold and the year you obtained them.

4. Describe any on-the-job training (Include in-service courses, "hands-on" experience, etc.)

5. List any special-interest courses and where taken.

B Information we need from the insured person to assess the claim (continued)

6. a) Do you have a valid driver's licence? ☐ Yes ☐ No

If '**yes**', indicate ☐ standard licence ☐ Other (specify) _____

b) Are there any restrictions on your driving as a result of your medical condition? ☐ Yes ☐ No If '**yes**', provide details.

Experience

1. Present employment: Briefly describe your duties and when you started in this job.

2. Past employment: Complete the following, providing details of your previous positions.

Name of employer	Job title and duties	Duration of employment From To

3. Job skills: What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc.) Where appropriate, give level of proficiency.

4. Community interests: Outline your past or present involvement with any community/church/volunteer organizations.

5. Hobbies

C Activities of daily living

This section is to be completed only if you are claiming for the Critically disabled–accident and sickness or the Critically disabled-deteriorated mental ability benefit.

1. Are you currently living at the address provided in Section B? ☐ Yes ☐ No

If '**yes**', who are you living with? ☐ Alone ☐ With spouse ☐ With family member ☐ Other

If '**no**' where are you currently living? ☐ Nursing home ☐ Hospital ☐ Home of family member ☐ Other

Telephone number where you can be reached: Telephone number

C Activities of daily living (continued)

2. a) Describe your physical dependency and its cause.

b) Date you first required assistance for 2 or more activities of daily living. Date (dd-mm-yyyy)

3. Do you require substantial physical assistance from another person to perform 2 or more of the activities of daily living as described below? ☐ Yes ☐ No If '**yes**', complete this chart, as the information is essential for review of your application for benefits.

Activity	Yes/No	Date (dd-mm-yyyy)	Details (include frequency of assistance)
Bathing (washing oneself)			
a) by sponge bath	☐ Yes ☐ No		
b) in the tub or shower	☐ Yes ☐ No		
c) getting in and out of the tub or shower	☐ Yes ☐ No		
Dressing (to put on, take off, fasten and unfasten)			
a) clothes usually worn	☐ Yes ☐ No		
b) medically necessary braces or artificial limbs	☐ Yes ☐ No		
Feeding (feeding oneself by getting food into the body, NOT including cooking or preparing a meal)			
a) from a plate, cup or table	☐ Yes ☐ No		
b) by feeding tube	☐ Yes ☐ No		
c) intravenously	☐ Yes ☐ No		
Toileting			
a) getting to and from the toilet	☐ Yes ☐ No		
b) getting on and off the toilet	☐ Yes ☐ No		
c) performing associated personal hygiene	☐ Yes ☐ No		
Transferring (moving to or from a bed or chair)			
a) moving into or out of a bed	☐ Yes ☐ No		
b) moving into or out of a chair	☐ Yes ☐ No		
c) moving into or out of a wheelchair	☐ Yes ☐ No		
Continence			
a) are you bladder incontinent	☐ Yes ☐ No		
b) are you bowel incontinent	☐ Yes ☐ No		
c) do you need help performing associated personal hygiene?	☐ Yes ☐ No		

Assistive devices are used to improve an individuals functioning. Assistive devices include but are not limited to adjustable beds, buttonhooks, canes, crutches, grab bars, seat lifts, transfer benches, wheelchairs, raised toilet seats, bath stools and sockaids.

Name of agency / person providing care	Is this person a licensed health care professional?	Address	Telephone number	Start date of service (dd-mm-yyyy)	Description of assistance provided
	☐ Yes ☐ No				
	☐ Yes ☐ No				

C Activities of daily living (continued)

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

   If '**yes**', list the devices you use and the activity of daily living it assists you with.

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

D Authorization

By signing this authorization, I, _____ authorize Sun Life Assurance Company of Canada, the plan administrator(s), and their advisors and service providers to collect, use and exchange information needed for underwriting, administration and adjudicating claims under this insurance coverage relating to _____ (the life insured) with any person or organization who has relevant information pertaining to this claim including health professionals, government agencies, provincial health care plans, institutions, the MIB, Inc., investigative agencies, insurers and reinsurers.

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I consent to Sun Life Assurance Company of Canada's use of my Social Insurance Number for tax-reporting purposes in connection with this claim.

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

Date (dd-mm-yyyy)	Signature of claimant (insured person)
	X

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

Application for access to the policy fund when disabled – WSIB Authorization

227 King Street South, PO Box 1601 Stn Waterloo, Waterloo, ON N2J 4C5

Note: This authorization should only be completed if you are receiving WSIB benefits.

Policy number _____ Name _____

This will authorize the Workers' Safety and Insurance Board to furnish Sun Life Assurance Company of Canada any medical, or non- medical information necessary to the evaluation of your disability claim.

My claim number with the WSIB is : _____

Date (dd-mm-yyyy)	Signature of claimant (insured person)
	X

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