Application for access to the policy fund when disabled – Attending physician'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 To be completed by patient

Policy number

First name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	Date of birth (dd-mm-yyyy)

Note: The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.

First name of physician completing this form	Last name		
☐ Family doctor ☐ Specialist (indicate specialty)			
Physician's address (street number and name)			Apartment or suite
City	Province	Postal code	Physician's telephone number

B To be completed by attending physician

The following information will be used to assess your patient's eligibility for disability benefits. Full and accurate answers expedite adjudication. The patient is responsible for the costs of obtaining medical evidence and the completion of this form, unless prohibited by law. Return form to patient or mail to Sun Life Financial at the above address.

Diagnosis

1. Primary _____ Symptoms _____
2. Secondary _____ Symptoms _____

History

1. Symptoms began or accident happened on Date (dd-mm-yyyy)
2. Illness or injury forced cessation of work on Date (dd-mm-yyyy)
3. Did an illness or injury force your patient to make a change in employment? ☐ Yes ☐ No
4. a) Has patient **ever** had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

   b) If '**yes**', state when and describe condition, _____
5. Provide details of any significant or lengthy illness for which you have treated the patient in the **last three years**.

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

B **To be completed by attending physician (continued)**

Clinical findings / Investigations

1. First visit Date (dd-mm-yyyy) Most recent visit Date (dd-mm-yyyy)

2. What was the nature of the visit or primary complaint last time you saw your patient?

3. Indicate if patient is right or left handed. ☐ right handed ☐ left handed

4. a) Height _____ b) Weight _____
   c) Blood pressure _____ d) Pulse _____

5. Cardiac (if applicable): ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

6.

Investigations (e.g., EKGs, x-rays, lab tests, etc.)	Date performed (dd-mm-yyyy)	Summary of results (Attach copies of all available reports.)

7. Has your patient been referred to any other physician(s)/specialist(s)? ☐ Yes ☐ No
   If '**yes**', complete the following chart.

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

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS

8. Was your patient hospitalized or confined to a nursing facility? ☐ Yes ☐ No Name of institution _____
   Date of admission Date (dd-mm-yyyy) Date of discharge Date (dd-mm-yyyy)

Treatment

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

2. List current medications prescribed and dosages.

3. Does this patient receive therapy? ☐ Yes ☐ No If '**yes**', indicate type (e.g. physio, psycho, etc.).

   Frequency: ☐ Daily ☐ _____ x per Week ☐ Other _____
   At: ☐ Outpatient dept. ☐ Therapist's ☐ Home

4. Has this patient ever had surgery? ☐ Yes ☐ No If '**yes**', indicate type of surgery.

   Date: ☐ performed Date (dd-mm-yyyy) ☐ planned Date (dd-mm-yyyy)

B To be completed by attending physician (continued)

5. Provide details for any other treatment or future plans for treatment.

Treatment or future plans for treatment	Dates (dd-mm-yyyy)

6. Summarize patient's response to treatment.

Current functional limitations

1. FUNCTION

	None	Slight	Moderate	Severe	Don't Know
Cognition	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Sensation	☐	☐	☐	☐	☐
Dexterity	☐	☐	☐	☐	☐
Psychological	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐

Visual Acuity L: _____ R: _____

Current GAF score: _____

Time restriction: ☐ min. ☐ hrs.

Time restriction: ☐ min. ☐ hrs.

Time restriction: ☐ min. ☐ hrs.

Time restriction: ☐ min. ☐ hrs.

Maximum recommended weight: _____ lbs _____ kgs

For injuries of the shoulder, back and neck, list limitations on flexion, extension and ROM.

2. Describe any functional limitations, physical or psychological, which you consider to be major obstacles to your patient's ability to work.

3. Were any functional capacity evaluations performed? ☐ Yes ☐ No If '**yes**', state when and type of evaluation.

Prognosis

1. Medically able to return to work at OWN occupation: ☐ Full-time Date (dd-mm-yyyy) ☐ Part-time Date (dd-mm-yyyy)

2. If medically unable to return to OWN occupation, when will patient be able to seek other employment?

☐ Full-time Date (dd-mm-yyyy) ☐ Part-time Date (dd-mm-yyyy)

3. Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No If '**yes**', provide details.

C Activities of daily living (to be completed by attending physician)

To be completed only if your patient is claiming for the critically disabled-accident and sickness or critically disabled-deteriorated mental ability benefit.

1. Date patient became dependent for **2 or more** activities of daily living (described below) Date (dd-mm-yyyy)

Bathing: Washing oneself by sponge bath, or in a bathtub or shower, including getting in and out of the tub or shower.
Dressing: The ability to put on, take off, fasten and unfasten clothes usually worn and medically necessary braces or artificial limbs.
Feeding: The ability to get food into the body through the mouth or by a feeding tube.
Feeding does not include cooking or preparing a meal.
Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring: Moving into or out of a bed, chair or wheelchair. This does not include getting into or out of the bathtub or shower, as we include this in bathing.
Continence: The ability to control bowel and bladder functions voluntarily, or to maintain a reasonable level of personal hygiene when not able to control bowel and bladder functions.

2. Indicate the level of assistance your patient needs with the following activities of daily living (ADL's). Check only the one box that best describes the patient's current level of activity in that ADL.

Activity of daily living (ADL)	No assistance needed; independent in ADL	Requires stand-by assistance (within arm's reach) each time the patient completes the ADL	Requires physical hands-on assistance from another person to complete the ADL	Date the patient became ADL dependent (dd-mm-yyyy)
Bathing	☐	☐	☐	
Dressing	☐	☐	☐	
Feeding	☐	☐	☐	
Toileting	☐	☐	☐	
Transferring	☐	☐	☐	
Continence	☐	☐	☐	

3. If you have any additional information describing your patient's ability to perform his/her ADL's, provide your comments below.

"**Cognitive Impairment**" means deteriorated mental ability resulting from organic brain disease such as Alzheimer's disease, irreversible dementia or brain injury. It is established by using clinical evidence and standard tests. The patient is considered to have deteriorated mental ability if he/she needs continual supervision by another person for protection from threats of physical health and safety as the result of a deterioration in or a loss of: a) short-term or long-term memory; b) orientation as to people, place and time; c) reasoning or; d) judgement as it relates to safety awareness.

4. Has any form of cognitive impairment been diagnosed? ☐ Yes ☐ No

If '**yes**', what is the diagnosis? _____ Date of onset: Date (dd-mm-yyyy)

If '**yes**', what specific diagnostic tests were administered? _____

5. Choose one of the following to best describe your patient's level of cognitive impairment.

☐ Patient has mild cognitive impairment that does not require continual supervision.

☐ Patient has severe cognitive impairment and requires continual supervision (including cueing) to protect him/herself from threats to his/her health and safety.

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

D Terminal illness (to be completed by attending physician)

To be completed only if your patient has been diagnosed with a terminal illness and the life expectancy is felt to be less than 2 years and no treatment is available which could alter the course of the decease process.

1. History of complaint of illness with first onset of symptoms.

2. Diagnosis _____ Date diagnosis confirmed Date (dd-mm-yyyy)

3. Provide copies of pathology and laboratory reports.

4. Was your patient hospitalized? ☐ Yes ☐ No If '**yes**', provide copies of admission and discharge reports.

   Date of admission Date (dd-mm-yyyy) Date of discharge Date (dd-mm-yyyy)

5. Provide details of your current assessment of patient's condition and treatment.

6. Prognosis and life expectancy.

7. Does your patient smoke? ☐ Yes ☐ No

   If '**no**', has your patient ever smoked? ☐ Yes ☐ No

   If '**yes**', provide details of smoking history, start and stop dates etc.

Physician's signature

Physician's first name	Last name	Telephone number
Date (dd-mm-yyyy)	Physician's signature X	

Notice to physician

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant 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 claimant or in harm to a third party.

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