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 Alzheimer's disease 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:

- A copy of your patient's clinical records relevant to the diagnosis of Dementia/Alzheimer's disease.
- Copies of all cognitive testing done within 12 months prior to diagnosis.
- Copies of all specialist reports confirming diagnosis.
- Details of admission to any program for Alzheimer's disease.

Note: Do not tell us about genetic testing or genetic testing results.

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 email us at *DISABLE@sunlife.com*.

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

Critical illness insurance – Physician's statement – Alzheimer's disease

Sun Life Financial

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

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Gender ☐ Male ☐ 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

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

2 Physician information

Ensure you enclose the following with this form:

- A copy of your patient's clinical records relevant to the diagnosis of Dementia/Alzheimer's disease.
- Copies of all cognitive testing done within 12 months prior to diagnosis.
- All specialist reports confirming diagnosis.
- Details of admission to any program for Alzheimer's disease.

Notes:

- **Do not tell us about genetic testing or genetic testing results.**
- The patient is responsible for the cost of completing this form.

Has a diagnosis of Alzheimer's disease been made? ☐ Yes ☐ No

Has a diagnosis of Dementia been made? ☐ Yes ☐ No

2 Physician information (continued)

Does your patient have a deterioration of:		If '**yes**', date deterioration started (dd-mm-yyyy)
Aphasia (speech)	☐ Yes ☐ No	
Apraxia (performing familiar tasks)	☐ Yes ☐ No	
Agnosia (recognizing objects)	☐ Yes ☐ No	
Disturbance in executive functioning.	☐ Yes ☐ No	
Intellectual capacity, impairment of memory and judgement resulting in significant reduction in mental and social functioning and requiring a minimum of 8 hours of daily supervision.	☐ Yes ☐ No	

Were any cognitive tests performed? ☐ Yes ☐ No

If '**yes**', provide details below.

Name(s) of test(s)	Date(s) (dd-mm-yyyy)	Score(s)

Were any tests repeated? ☐ Yes ☐ No

If '**yes**', provide details below.

Name(s) of test(s)	Date(s) (dd-mm-yyyy)	Score(s)

Has affective or schizophrenic disorders or delirium been ruled out? ☐ Yes ☐ No

If '**yes**', provide name(s) of test(s).

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

Physician/hospital name	Address

2 Physician information (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.

Name	Relationship to patient	Age at onset	Year of 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.

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.