Sun Life Financial
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 loss of independent existence definition of the policy. In addition to completing the form, please also provide us with the following:

- copies of all clinical notes relating to the diagnosis of the underlying condition,
- a copy of the Plan of Care created by the agency providing the care,
- copies of any specialist or hospital reports, and
- copies of hospital admission and discharge summaries.

Note:

- **Do not tell us about genetic testing or genetic test results.**
- **To qualify for the benefit, your patient must have a definite diagnosis of the total inability to perform, by oneself, at least 2 or more activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.**

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 – Loss of Independent Existence (LOIE)

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's information – to be completed by attending physician

In addition to answering the following questions, ensure you enclose the following with this form:

- copies of all clinical notes relating to the diagnosis of the underlying condition,
- a copy of the Plan of Care created by the agency providing the care,
- copies of any specialist or hospital reports, and
- copies of hospital admission and discharge summaries.

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

2.1 Please provide the information below.

What medical condition is causing the LOIE?	Date of diagnosis (dd-mm-yyyy)

Date this person became your patient (dd-mm-yyyy)	Date patient first consulted you for this condition (dd-mm-yyyy)	Date patient first consulted another physician for this condition (dd-mm-yyyy)

Will the condition named above improve? ☐ Yes ☐ No	Has a referral to a community care agency been made? ☐ Yes – Date (dd-mm-yyyy) ______ ☐ No – if no why not? ______

Name of assessor (or agency if applicable)	Reference number	Telephone number

2 Physician information (continued)

2.2 Indicate what diagnostic test was used to establish the diagnosis. **Do not tell us about genetic testing or genetic testing results.**

2.3 Indicate your patient's ability to do the following activities of daily living.

Activity	Yes	No	By oneself with an assistive device.
Wash themself by sponge bath, or in a bathtub or shower?	☐ Yes	☐ No	☐ By oneself with an assistive device.
Manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained?	☐ Yes	☐ No	☐ By oneself with an assistive device.
Consumed food or drink that has already been prepared?	☐ Yes	☐ No	☐ By oneself with an assistive device.
Put on and remove necessary clothing, braces, artificial limbs or other surgical appliances?	☐ Yes	☐ No	☐ By oneself with an assistive device.
Get themself on and off the toilet and maintain personal hygiene?	☐ Yes	☐ No	☐ By oneself with an assistive device.
Move in or out of a chair, wheelchair or bed?	☐ Yes	☐ No	☐ By oneself with an assistive device.

2.4 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**

2.5 Does your patient smoke? .... ☐ Yes ☐ No If '**no**', has your patient **ever** smoked?................................ ☐ Yes ☐ No

If '**yes**', provide details of smoking history.

2.6 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 mail the completed original form to:

Sun Life Assurance Company of Canada
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.

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