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 blindness, deafness or loss of speech definition of the policy. In addition to completing the form, please also provide us with the following:

- copies of all relevant diagnostic tests (visual acuity, field of vision, auditory),
- copies of any specialist or hospital reports, and
- if the loss was due to an accident, a copy of any toxicology report done immediately following the accident.

Notes:

- **Do not tell us about genetic testing or genetic test results.**
- **To qualify for blindness, your patient must have total and irreversible loss of vision in both eyes evidenced by the:**
  - **corrected visual acuity being 20/200 or less in both eyes, or**
  - **field of vision being less than 20 degrees in both eyes.**
- **To qualify for deafness, your patient must have a total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500-3000 hertz.**
- **To qualify for loss of speech, your patient must have total and irreversible loss of the ability to speak as the result of physical injury or disease for a period of at least 180 days. 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.

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

Sun Life Financial

Critical illness insurance – Physician's statement – Blindness, Deafness or Loss of speech

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 about 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 – to be completed by treating physician

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

- copies of all relevant diagnostic tests (visual acuity, field of vision, auditory),
- copies of any specialist or hospital reports, and
- if the loss was due to an accident, a copy of any toxicology report done immediately following the accident.

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

2 Physician information (continued)

2.1 Which condition(s) apply to your patient?

☐ Blindness ☐ Deafness ☐ Loss of speech

Please provide a brief outline of the medical condition or the accident leading to your patient's diagnosis.		
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)

Date of loss (dd-mm-yyyy)	Is loss irreversible? ☐ Yes ☐ No

2.2 Complete any section(s) that apply to your patient.

Blindness

What is the cause of loss of vision?	
What is the corrected vision or the field of vision in each eye? L ____________ R ____________	On what date was this test performed? (dd-mm-yyyy)

Deafness

What is the cause of loss of hearing?		
What is the auditory threshold in each ear? L ____________ R ____________	What is the speech threshold in each ear? L ____________ R ____________	On what date was this test performed? (dd-mm-yyyy)

Loss of speech

What is the cause of loss of speech?
Has the loss of speech lasted long than 180 days? ☐ Yes ☐ No

2.3 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**	**Date (dd-mm-yyyy)**	**Reason for visit**

2.4 Were alcohol or drugs a contributing factor? .... ☐ Yes ☐ No

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

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 Physician information (continued)

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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