

Advance payment of death benefit – Authorization and attending physician statement

Please complete section A and B of the form and have your physician complete section C.

A To be completed by the patient

Policy No. _____

Mr. Miss

Name: Mrs. Ms. _____
Last name First name

B 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 my request for an advance payment of the death benefit, including health professionals, government agencies, provincial health care plans, institutions, the Medical Information Bureau (MIB), investigative agencies, insurers and reinsurers.

A photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect while this request is processed.

_____ Date _____
Signature of insured person day month year

C To be completed by attending physician

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

2. Please provide copies of pathology and laboratory reports.

3. Diagnosis _____ Date diagnosis confirmed _____
day month year

4. Was your patient hospitalized? No Yes

If Yes, please attach all admission and discharge summaries.

5. Please provide details of your current assessment of patient's condition and treatment. (if more room is required please attach additional information)

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6. Prognosis and life expectancy _____

7. Does your patient smoke? No Yes

If no, has your patient ever smoked? No Yes

If yes, please provide details of smoking history, start and stop dates etc. _____

Any information provided by you to Sun Life Assurance Company of Canada regarding this request for an advance payment of the death benefit may be disclosed to the insured person and/or those authorized by him/her 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 insured person or in harm to a third party.

Name of physician completing this form _____
Last name First name

Family doctor Specialist (indicate specialty) _____

Physician's address _____
No. & Street Suite no. City/Town Province

Physician's phone no. (_____) - _____ Postal code _____

Physician's signature X _____ Date

day	month	year							