Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo, Waterloo, ON N2J 4C5

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)

_____

_____

_____

_____

_____

Products are issued by Sun Life Assurance Company of Canada

Please send original after faxing a copy.

Advance payment of death benefit – Authorization and attending physician statement

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 ✗_____ Date ____ ____ ____
day month year

Products are issued by Sun Life Assurance Company of Canada

Please send original after faxing a copy.