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Disability Insurance Claim

Policy 83028

Sun Life Financial

What information is required for a Disability Claim?

Checklist for the Claimant

☐ a completed and signed Claimant Statement
☐ a completed and signed Education, Training and Experience Statement
☐ a completed and signed Attending Physician's Statement*

* You must complete the Patient Authorization on the Attending Physician's Statement. Ask your doctor to complete the Attending Physician's Statement with as many details as possible. The statement should be immediately given to you to submit with your claim.

To prevent delays, please be sure the forms are fully completed and provide as much information as possible to help with the adjudication of your claim. Sun Life Assurance Company of Canada can only process your claim when we have received all of the above documents.

Important notes

- Proof of claim must be submitted within 120 days of the date of disability.
- No benefits are payable during the qualifying period.
- Any costs for information to substantiate your claim is your responsibility.
- The Attending Physician's Statement must be completed by a qualified Physician or Specialist practising in Canada or the United States of America.
- If your medical condition improves or deteriorates, you must notify Sun Life Assurance Company of Canada immediately.
- Please retain a photocopy of your claim forms for your records.
- Sun Life Assurance Company of Canada will inform you if your claim is subject to further investigations.
- Until Sun Life Assurance Company of Canada advises you in writing of the decision, it is your responsibility to continue paying your payments in full.
- For questions about your claim, you may call Sun Life Assurance Company of Canada at 1-877-271-8713.

Please submit your claim to:

Knowledge First Foundation
Attention: Insurance Claim
50 Burnhamthorpe Road West Suite 1000
Mississauga ON L5B 4A5

For questions regarding submitting your claim, please call 1-800-363-7377 or send an email to *contact@kff.ca*

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Claimant's Statement

Proof of claim must be submitted within 120 days of the date of disability.
Instructions
- Print clearly in block letters.
- The "Claimant's Statement" must be fully completed, ensuring all sections are completed.
- Please sign and date the Claimant Authorization.

1 Claimant information

First name		Last name			
Date of birth (dd-mm-yyyy) _ _	☐ Male ☐ Female	Language	☐ English ☐ French	Telephone number _ _	☐ Bus. ☐ Res.
Email Address					
Address (street number and name)				Apartment or unit	
City		Province		Postal code	

2 Details of disability

1. a) To your knowledge, what is the diagnosis of your illness?

b) What treatment are you receiving at present (medicine, diets, advice, physiotherapy, etc)?

c) Describe how your condition prevents you from working and from performing the duties of your occupation.

d) On what date did the first symptoms of your illness or injury appear? Date (dd-mm-yyyy) _ _

e) On what date did you first consulted a physician for your present illness or injury. Date (dd-mm-yyyy) _ _

2. a) If disability is due to an accident, where did the accident happen? Date of accident Date (dd-mm-yyyy) _ _

☐ at home ☐ at work ☐ elsewhere (where)? _____

b) How did the accident happen?

If a motor vehicle accident, were you the operator of the vehicle? ☐ Yes ☐ No

If *yes*, forward copies of the police accident report if possible.

3. From what date have you been totally and continuously disabled from performing your occupation? Date (dd-mm-yyyy) _ _

4. a) Are you now ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐ Mobile?

b) Describe your daily activities.

2 Details of disability (continued)

4. c) Have you received a salary for any jobs since becoming disabled? ☐ Yes ☐ No If *yes*, please give details.

d) On what date do you expect to be able to resume active employment either full or part time? Date (dd-mm-yyyy) – –

5. a) Give names and addresses of all physicians who attended you during your present illness or injury.

b) Give names and addresses of all physicians who have attended you in the past 3 years and provide details.

Nature of illness/injury	Dates of visits/treatments (dd-mm-yyyy)	Treatment prescribed (medicines, diets, etc.)	Names and addresses of physicians
	– –		
	– –		
	– –		

6. Were you hospitalized for this disability? ☐ Yes ☐ No If *yes*, list any surgery performed.

Type of surgery	Date of surgery (dd-mm-yyyy)	Name of hospital	Name of surgeon
	– –		
	– –		

7. Please indicate the policy numbers of any group or individual insurance policies under which you are insured by Sun Life Assurance Company of Canada.

3 Claimant authorization

I certify that the statements in this form are true and complete. I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers (i) to collect, use, and disclose information about me (excluding health information) with the Knowledge First Financial for the purpose of administering my claim and (ii) to collect, use and disclose information about me (including health information) needed for underwriting, administration and adjudicating claims under this Group Policy with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the duration of the claim.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

4 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Education, Training and Experience

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies,is committed to keeping information concerning this claim confidential.

Instructions

- This information is important to the assessment and administration of your claim.
- Please complete in full. (Attach a separate sheet if necessary).

1 Claimant information

First name		Last name			
Date of birth (dd-mm-yyyy) _ _	☐ Male ☐ Female	Language	☐ English ☐ French	Telephone number _ _	☐ Bus. ☐ Res.
Email Address					
Address (street number and name)				Apartment or unit	
City		Province		Postal code	

2 Education

Indicate the highest grade level of education completed:

☐ Grade 6 or under Grade ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Name of technical or trade school attended	Type of diploma obtained
Name of college or university attended	Number of years completed
Type of degree obtained	Name major

Language:

a) English ☐ Written ☐ Spoken b) French ☐ Written ☐ Spoken c) Other _____ ☐ Written ☐ Spoken

3 Training

Name of technical or administrative courses taken.

Name apprenticeships completed.

List any certificates/diplomas/licences you hold and the year you obtained them.

3 Training (continued)

Describe any on-the-job training (includes in-service courses, "hands-on" experience, etc.)

List any special-interest courses and where taken.

Do you hold a valid driver's licence? ☐ No ☐ Yes

If *yes*, ☐ standard licence ☐ Other (specify) _____

Are there any restrictions on your driving as a result of your medical condition? ☐ No ☐ Yes

If *yes*, explain.

4 Experience

Present Employment: Briefly describe your duties and when you started this job.

Past Employment: Please complete the following, providing details of your previous positions.

From (mm-yyyy)	To (mm-yyyy)	Employer	Job title and duties
–	–		
–	–		
–	–		
–	–		
–	–		

Job Skills: What skills have you acquired in your current and previous jobs? (e.g. Typing, Computer skills, operation of equipment, supervisory skills, etc.) Where appropriate, give level of proficiency.

Community Interests: Outline your past or present involvement with any community/church/volunteer organizations.

4 Experience (continued)

Hobbies

5 Claimant authorization

I certify that the statements in this form are true and complete. I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers (i) to collect, use, and disclose information about me (excluding health information) with the Knowledge First Financial for the purpose of administering my claim and (ii) to collect, use and disclose information about me (including health information) needed for underwriting, administration and adjudicating claims under this Group Policy with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the duration of the claim.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

6 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

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Attending Physician's Statement

Proof of claim must be submitted within 120 days of completion of the date of disability.

Instructions

- Any cost incurred for the completion of this form is the patient's responsibility.
- The purpose of this report is to assist us in making a disability determination. In filling out this report please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

1 Patient information

First name		Last name			
Date of birth (dd-mm-yyyy) _ _	☐ Male ☐ Female	Language	☐ English ☐ French	Telephone number _ _	☐ Bus. ☐ Res.
Email Address					
Address (street number and name)				Apartment or unit	
City		Province		Postal code	

2 Patient authorization

I authorize my physician to collect, use and disclose information with Sun Life Assurance Company of Canada, its agents, service providers and reinsurers for the purposes of underwriting, administration and adjudicating my claim under this insurance plan. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Signature of claimant	Date (dd-mm-yyyy)
X	_ _

3 Medical information

1. History

a) When did symptoms first appear or accident happen? Date (dd-mm-yyyy) _ _

b) Date patient ceased work because of this disability: Date (dd-mm-yyyy) _ _

c) Has patient ever had same or similar condition? ☐ Yes ☐ No If *yes*, state when and describe.

Date (dd-mm-yyyy)	Details:
_ _	

d) If the condition is long-standing, how would you describe its evolution since onset?
☐ Improved ☐ Remained the same ☐ Slight deterioration ☐ Significant deterioration

e) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

f) Is condition due to, or related to, complication of pregnancy? ☐ Yes ☐ No If *yes*, please indicate date of confinement. Date (dd-mm-yyyy) _ _

g) Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No

h) Is this condition due to a self-inflicted injury or attempted suicide? ☐ Yes ☐ No

i) Is this condition due to elective cosmetic or experimental surgery or treatment? ☐ Yes ☐ No

2. Diagnosis (including any complications)

a)

Primary diagnosis
Secondary diagnosis

3 Medical information (continued)

b) Subjective symptoms

c) Objective findings (include current X-rays, EKG's, laboratory data and any clinical findings)

3. Date of treatment

a) Date of first visit — Date (dd-mm-yyyy) _ _

b) Date of latest visit — Date (dd-mm-yyyy) _ _

c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

4. Nature of treatment (including surgery, therapy and medications prescribed, if any)

5. Progress

a) Has patient: ☐ Recovered ☐ Remained unchanged ☐ Improved ☐ Retrogressed

b) Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

c) If patient was hospitalized, provide name and address of hospital.

Name of hospital	Address of hospital

Hospitalized from — Date (dd-mm-yyyy) _ _ through — Date (dd-mm-yyyy) _ _

6. Cardiac (if applicable)

a) Functional capacity (American Heart Association)

☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

b) Blood pressure (last visit) — Systolic / Diastolic

7. Physical impairment

☐ Class 1 – No limitation of functional capacity; capable of physical activity (0 - 10%)

☐ Class 2 – Slight limitation of functional capacity; capable of light manual activity (15 - 30%)

☐ Class 3 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35 - 55%)

☐ Class 4 – Marked limitation (60 - 70%)

☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity (75 - 100%)

Remarks:

a) Explain how the patient's physical limitations prevent him/her from performing the essential duties of his/her occupation.

3 Medical information (continued)

b) Do you feel the patient could return to work provided some of his/her duties could be modified. If so, state what these would be and the date you anticipate the patient can return to modified duties.

8. Mental/Nervous Impairment (if applicable)

Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF

Axis 1 (Primary)	
Axis 2	
Axis 3	
Axis 4	
Axis 5 – GAF current	Lowest in past year

State at which GAF level the patient would be fit to resume full time work.

Remarks:

a) Explain how the patient's psychological limitations prevent him/her from performing the essential duties of his/her occupation.

b) Do you feel the patient could return to work provided some of his/her duties could be modified. If so, state what these would be and the date you anticipate the patient can return to modified duties.

9. Prognosis

	Patient's job	**Any other work**
a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
b) If *no*, when was patient able to resume work?	Date (dd-mm-yyyy) – –	Date (dd-mm-yyyy) – –
c) If *yes*, when do you expect patient will recover sufficiently to resume work?	Date (dd-mm-yyyy) – –	Date (dd-mm-yyyy) – –
	☐ Indefinite ☐ Never	☐ Indefinite ☐ Never

d) Please provide the dates the patient consulted you or any other physician for this or any other condition in the last 3 years.

Dates (mm-yyyy)	History (physical findings)	Diagnosis	Treatment
–			
–			

e) To assist us to promptly assess this patient's disability claim, please provide copies of all available test results, consultation notes, specialist reports and hospital records.

3 Medical information (continued)

f) Indicate the names and addresses of any other physicians who have treated this patient in the last 3 years.

Name	Specialty	Address	Telephone, Fax
			– –
			– –

4 Attending physician's signature

I certify that the information in this form is true and correct.

Physician's first name (please print)	Last name	Speciality
Address (street number and name)		Suite or unit
City	Province	Postal code
Telephone number – –	Fax number – –	
Physician's signature X		Date (dd-mm-yyyy) – –