Business Loan Insurance Plan
Disability Insurance Claim

Group Policy 51000*

Before submitting a disability claim:

- Complete and sign the Claimant's Statement for Disability.
- Sign and complete the Patient Authorization on the Attending Physician's Statement.
- The doctor must complete the Attending Physician's Statement with as many details as possible.
- The complete disability claim form consists of 3 parts

    - Employer's Statement
    - Claimant's Statement, and
    - Attending Physician's Statement

Sun Life Assurance Company of Canada can only process your claim when we have received all 3 parts fully completed. To prevent delays, please be sure the forms are completed in full and provide as much information as possible to help with the adjudication of the claim.

- As our consulting physicians do not examine you, we depend on the quality of the medical information given by your doctor to assess your claim.
- Sun Life Assurance Company of Canada evaluates the information included on the statements and determines if you are medically unable to work.

To ensure your claim is processed promptly:

- Submit your claim to: Insurance Service Centre
  P.O. Box 53, Postal Station A
  Mississauga, Ontario
  L5A 2Y9
  Transit: 04523
- Ensure that all required forms are fully completed and returned as soon as possible.
- Please read and follow these instructions carefully.

Until your claim is approved:

- Sun Life Assurance Company of Canada will inform you if further information is required in order to assess your claim.
- You are responsible for continuing to make your loan payments in full until your claim is assessed and benefit payments begin.
- For questions about your claim, you may call the Insurance Service Centre at 1-800-769-2523.

Important Notes:

- Proof of claim must be submitted within 150 days of the date of disability.
- There is a 60 day waiting period. If your claim is approved, payment of benefits will commence after completion of the waiting period.
- Any costs for information to substantiate the claim are your responsibility.
- The Attending Physician's Statement must be completed by a licensed Doctor of Medicine.
- It is your responsibility to notify Sun Life Assurance Company of Canada of your return-to-work date.

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Employer's Statement (to be completed by claimant if self-employed and submitted with the documentation described in #9 below) Proof of claim must be submitted within 150 days of the date of disability.

Instructions:
The "Employer's Statement" must be fully completed, making sure all questions are answered.
Please be sure to sign and date the Certification.

1. Employee Information

Name of Employee:		
Employee's Address: Number and Street City Province Postal Code		
Employee's commencement date of employment (mm/dd/yyyy)	Employee's last scheduled working day (mm/dd/yyyy)	Employee's last day worked (mm/dd/yyyy)
Is this Employee employed in the business as a family member? ☐ Yes ☐ No		

2. Work Details

1. What was the reason for discontinuing work? ☐ Vacation ☐ Lay-off ☐ Leave of absence ☐ Disability ☐ Other/Specify _____
2. Date employee is expected to return to work (mm/dd/yyyy):
   or
   Date employee returned to work (mm/dd/yyyy):
3. If the disability is the result of an accident, have you submitted a report of this accident to WCB/WSIB? ☐ Yes ☐ No
4. What was the employee's occupation or assignment at the date he/she ceased work? Sun Life Assurance Company of Canada requires a copy of the employee's job description, if none is available then list all essential job duties performed.

5. Is this position ☐ Full time? ☐ Part-time? ☐ Seasonal? Indicate number of hours worked per week _____
   If seasonal, indicate inclusive annual dates of employment:

From (mm/dd/yyyy)	To (mm/dd/yyyy)

6. Where does he/she conduct business? ☐ home office ☐ business office ☐ other _____
7. Give dates and details of sick leave during the 12 months preceding commencement of disability.

8. If he/she changed occupations or assignments during the 12 months before ceasing work, describe the previous occupation or assignment and give the reason for change and the effective date of this change. Include changes to his/her hours worked per day/week.

9. If you are self-employed: The eligibility requirements of this contract state that you must be working a minimum average of 20 hours per week in order to qualify for this insurance. If you are self employed, we must confirm the above. We require a copy of your income tax report you filed last year and all pay stubs for the period from the last calendar year to the date of disability.

3. Certification and Signature

I certify that, according to the records of this organization, the above information is correct.

Name of Authorized Official (Please Print):		Title:
Name of Employer:	Telephone No.:	Fax No.:
Address: Number and Street City Province Postal Code		
Signature of Authorized Official:		Date (mm/dd/yyyy):

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Claimant's Statement

Proof of claim must be submitted within 150 days of the date of disability.

Instructions

The "Claimant's Statement" must be fully completed, making sure all questions are answered.
Please be sure to sign and date the Claimant Authorization.
Print clearly in block letters.

Is a separate Accidental Dismemberment Claim being submitted as well? ☐ Yes ☐ No

1. Claimant Information

Claimant's Name:		Claimant's SRF#
Address: Number and Street City		Province Postal Code
Sex ☐ Male ☐ Female	Language ☐ English ☐ French	Bus. Telephone No. Res. Telephone No.
Business Name	Business SRF#	Business Loan #

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, diet, advice, physiotherapy)?

c) What, if any, restrictions has your physician placed on your work activities?

d) What occupational duties are you no longer able to perform as a result of your condition?

e) On what date did the first symptoms of your illness or injury appear? (mm/dd/yyyy) _____

f) Date on which you first consulted a physician for your present illness or injury: (mm/dd/yyyy) _____

2. a) If the disability is due to an accident, where did the accident happen?
☐ At home ☐ at work ☐ elsewhere (where)? _____
Date of accident (mm/dd/yyyy) _____

b) How did the accident/injury 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? (mm/dd/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 performed any work or activities for compensation or profit 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?
(mm/dd/yyyy) _____

5. a) Give names and addresses of all physicians who you consulted with or sought treatment from during your present illness or injury.

b) Give names and address of all physicians who you consulted with or sought treatment from in the past three years and provide details.

Nature of Illness/Injury	Dates of visits/treatments	Treatment prescribed (medicines, diet, etc.)	Name and addresses of physicians

c) If as a result of any of these prior illnesses/injuries, a change in habits or work restrictions were advised, please describe what the changes were and from what date.

6. List any surgery performed during any hospitalizations in the past three years.

Type of surgery	Date of surgery	Name of hospital	Name of surgeon

7. If the Attending Physician's Statement of Disability is not being sent with this claim form, is your doctor sending it directly?
☐ Yes ☐ No If no, please explain.

8. 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 to collect, use and exchange information about me needed for underwriting, administration and adjudication of my claim under this Plan with each other and/or persons or organizations having relevant information pertaining to my claim, including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event this Plan is audited.

A photocopy of this authorization is as valid as the original and shall continue to have effect throughout my claim.

Signature of Claimant	Date (mm/dd/yyyy)

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Attending Physician's Statement

Proof of claim must be submitted within 150 days of the date of disability.

Instructions

To keep your report confidential, please return it to the claimant to be submitted with their claim form.

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. When filling out this report, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to treatment to enable us to make this determination.

1. Patient Authorization

I authorize my doctor to use, release and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purpose of underwriting, administration and adjudication of my claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.

Name of Patient	Signature	Date (mm/dd/yyyy)

2. Medical Information

1. History

a) When did symptoms first appear or accident/injury happen? (mm/dd/yyyy) _____

b) Date the patient ceased work because of incapacity. (mm/dd/yyyy) _____

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

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) If condition due to accident/injury, how did the accident/injury occur?

Was the patient impaired by alcohol or drugs at the time of the accident/injury? ☐ Yes ☐ No ☐ Unknown

g) Is condition due to, or related to, pregnancy? ☐ Yes ☐ No
If yes, please indicate date of confinement. (mm/dd/yyyy) _____

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

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

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

2. Diagnosis (including any complications)

a)

Primary Diagnosis
Secondary Diagnosis

b)

Subjective symptoms

c)

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

2. Medical Information (continued)

3. Date of Treatment

a) Date of first visit: (mm/dd/yyyy) _____

b) Date of last visit: (mm/dd/yyyy) _____

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

4. Nature of Treatment (including surgery 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) Has patient been hospital confined? ☐ Yes ☐ No If yes, give name and address of hospital.

Confined from: (mm/dd/yyyy) _____ through: (mm/dd/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 heavy work; no restrictions. (0 - 10%)

☐ Class 2 - Medium manual activity (15 - 30%)

☐ Class 3 - Slight limitation of functional capacity; capable of light work (35 - 55%)

☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. (60 - 70%)

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

☐ Specific limitation? (bending, lifting, etc.) _____

Remarks:

a) Explain what prevents the patient from a return to full or partial duties.

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

2. Medical Information (continued)

8. Mental/Nervous Impairment (if applicable)

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

Axis I (Primary)	
Axis II	
Axis III	
Axis IV	
Axis V - 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/hours could be modified? If so, state what these would be and the date you anticipate the patient can return to modified duties/hours.

9. Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? ☐ Yes ☐ No

10. **Prognosis**

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

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

Dates (month/year)	History (Physical Findings)	Diagnosis	Treatment

e) Provide us with any copies of any available test results, hospital records, consultation notes, and specialist reports in the last three years.

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

Name/Specialty	Reason for referral/treatment	Address	Telephone/Fax

3. Attending Physician's Signature

Date (mm/dd/yyyy)	Signature	Degree/Specialty	Telephone No. ( )
Address: Number and Street			
City	Province	Postal Code	