



Attending Physician's Statement Short-Term Disability: General



Member Authorization

This section must be completed and signed by the member to authorize release of medical information.

Contract Number	Member ID	Name - first and last name (Quebec residents - maiden name)	Date of birth (d/m/y)
I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.			
Member's signature			Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

Any cost for information to substantiate this claim will be the member's responsibility.

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant 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 claimant or in harm to a third party.

Is patient's condition due to injury or sickness caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Last day at work (d/m/y)	Date of initial visit (d/m/y)	Expected duration of disability
Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Date and nature of surgery (d/m/y)	Type of anaesthetic
Patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of referring physician	Have you referred patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of physician(s)/other
Date of first and all subsequent visits during present period of absence from work (d/m/y)	Date first unable to work because of disability (d/m/y)	Is patient competent to endorse cheques? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Diagnosis

Primary	Secondary
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History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression
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Treatment Plan

Please list medication, dosage and frequency.
Please identify any other treatment prescribed, including nature and frequency (ie therapy).

Remarks

Please note any psychological or social difficulties which may delay recovery

Prognosis

Please note any restrictions, any complications, and/or limitations, and state prognosis
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If Cardio-related

Canadian Cardiovascular Class	OR	American Heart Association Class	If class 3 or 4, please enclose a copy of the report of the graded exercise test	Physical findings BP	Weight
Rhythm description		Angina (frequency, severity, patterns)			
Complications (e.g. cerebral vascular, peripheral vascular or diabetic conditions)					

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:
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Investigations

Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

Please enclose copies of all relevant reports which objectively support the claimed disability described above (e.g. x-rays, myelograms, C.T. scans, bone scans, etc.)

Return this form to your patient or send the form to Sun Life Assurance Company of Canada Disability Management office.

Vancouver:

Fax: 1 866 639-7829
PO Box 48810 Stn Bentall
Vancouver BC V7X 1A6

490S-P-ARA-E-06-06 (G3395-E)

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

Attending Physician's Statement Short-Term Disability: Psychiatric



Member Authorization

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Member's signature			Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

Any cost for information to substantiate this claim will be the member's responsibility.

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant 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 claimant or in harm to a third party.

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

Is patient's condition due to injury or sickness caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Last day at work (d/m/y)	Date of initial visit (d/m/y)	Expected duration of disability
Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)		
Patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of referring physician	Have you referred patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of physician(s)/other
Date of first and all subsequent visits during present period of absence from work (d/m/y)	Date first unable to work because of disability (d/m/y)	Is patient competent to endorse cheques? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Diagnosis

Axis 1 (Primary)	
Axis 2 (Secondary)	
Axis 3	
Axis 4	
Axis 5	
GAF current	lowest in past year

History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression
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Treatment Plan

List medications, dosage frequency and psychotherapy/cognitive behavioural therapy
Counselling (first appointment, last appointment, frequency, results)

Remarks

Please note any psychological or social difficulties which may delay recovery

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:
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Prognosis

Please note any restrictions, any complications, and/or limitations, and state prognosis
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Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

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490S-P-ARA-E-06-06 (G3395-E)

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Attending Physician's Statement Short-Term Disability: Pregnancy



Member Authorization

This section must be completed and signed by the member to authorize release of medical information.

Contract Number	Member ID	Name - first and last name (Quebec residents - maiden name)	Date of birth (d/m/y)
I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.			
Member's signature			Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

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Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant 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 claimant or in harm to a third party.

Is patient's condition due to injury or sickness caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Last day at work (d/m/y)	Date of discharge (d/m/y)	Is patient competent to endorse cheques? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of referring physician		Expected duration of disability
Have you referred patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of physician(s)/other		
Date first unable to work because of disability (d/m/y)	Para	Gravida	Expected due date
Age			
Date of first and all subsequent visits during present period of absence from work (d/m/y)			

Diagnosis

Primary	Secondary
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History

List all symptoms and abnormal physical findings relevant to the complications in this pregnancy. Please note severity, date of onset and progression			
.....			Pre-pregnant weight
.....			Current weight
.....			Height

Treatment Plan

List medications, dosage and frequency			
.....			Date of hospital admissions (d/m/y)
.....			
.....			

Prognosis

Please note any restrictions, any complications, and/or limitations, and state prognosis			
.....			
.....			

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:		
.....			
Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

Return this form to your patient or send the form to Sun Life Assurance Company of Canada Disability Management office.

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Attending Physician's Statement Short-Term Disability: Musculo-Skeletal/ Motor Vehicle Accident



Member Authorization

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I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that a photocopy or electronic version of this authorization is as valid as the original.			
Member's signature			Date (d/m/y)

1 General Information

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Is patient's condition due to injury or sickness caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Is patient competent to endorse cheques? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last day at work (d/m/y)	First day patient seen (d/m/y)	Expected duration of disability	
Patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of referring physician		
Have you referred patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of physician(s)/other		
Date of first and all subsequent visits during present period of absence from work (d/m/y)			Date first unable to work because of disability (d/m/y)

Diagnosis

Primary	Secondary	
Date symptoms appeared or accident happened (d/m/y)	Has patient had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state when and describe

History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression
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Physical Findings

	Weight	Height
If result of motor vehicle accident, give accident date (d/m/y)	Expected return to work date will be in 2 to 3 weeks <input type="checkbox"/>	Other, please explain
	Expected return to work date will be in 4 to 6 weeks <input type="checkbox"/>	

Treatment Plan

List medications, dosage frequency and physiotherapy (please note any psychological or social difficulties which may delay recovery)	
Date and nature of surgery (d/m/y)	Type of anaesthetic

Prognosis

Please note any restrictions, any complications, and/or limitations, and state prognosis
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Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:
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Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

Please enclose copies of all relevant reports which objectively support the claimed disability described above (e.g. x-rays, myelograms, C.T. scans, bone scans, etc.)

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