



Plan Member's Statement Claim for Short-Term Disability Benefits



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

1 Member information

In order to avoid any delays in the assessment of your claim, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If the Plan Sponsor pays any portion of the premium, the plan is taxable. Your Social Insurance Number is required for issuance of T4As.

| | | | | | |
|---|-----------|-------------------------|--|------------------------------------|--|
| Contract Number | | Member ID | | Date of Birth (d/m/y) | |
| Name - first and last name (Quebec residents - maiden name) | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (street number and name, apartment or suite) | | | | | |
| City | | Province | | Postal Code | |
| Occupation | Job Title | Social Insurance Number | | Daytime Telephone Number () | |

2 Plan Sponsor information

| | | | | | |
|----------------|--|--------------------------------------|--|-------------|--|
| Company Name | | Division Number | | | |
| Street Address | | | | | |
| City | | Province | | Postal Code | |
| Contact Person | | Contact's Telephone Number () | | Ext. | |

3 About your illness or injury

When was your last day at work?

What is the date you returned or expect to return to work?

During this period, have you worked at any occupation or employment? No Yes Please explain.

What are the current symptoms preventing you from working?

Is your condition related to pregnancy?

No Yes What is your delivery date?

Please ensure your physician completes the appropriate pregnancy related form.
Please describe your complications, if any.

4 Disability as a result of an accident

Is your illness or injury due to an accident?

No Yes Where did the accident happen? at home at work elsewhere

Date of the accident Time of the accident

Were you working for your Plan Sponsor at the time of the accident? Yes No

Please describe how your illness or injury occurred.

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| |

Is your illness or injury due to a motor vehicle accident?

No Yes Please enclose a copy of the accident report.

| | | |
|----------------------------|---------------------|-----------------------------|
| Name of insurance adjuster | Auto Carrier Number | Telephone number () |
|----------------------------|---------------------|-----------------------------|

If your disability is the result of an accident, are you taking legal action against any other person or organization?

No Explain why you are not taking legal action.

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| |

Yes Please complete the following:

| | | |
|----------------|----------|-----------------------------|
| Name of Lawyer | | |
| Address | | Telephone number () |
| City | Province | Postal Code |

On what date did the legal action start?

Has a settlement been reached? No Yes Please attach a copy of the terms of the settlement.

5 Your other income

Please list any amounts of money you are currently receiving or expect to receive each week or month from the following sources. We may take some of these amounts into consideration when we calculate your Short-Term Disability benefit.

| Source | Are you eligible for this benefit? | | Insurance Co. & Policy Number | Have you applied for this income? | | Are you receiving or do you expect to receive this income? | | Amount per <input type="checkbox"/> Week <input type="checkbox"/> Month |
|---|------------------------------------|--------------------------|-------------------------------|-----------------------------------|--------------------------|--|--------------------------|---|
| | Yes | No | | Yes | No | Current | Expected | |
| Any other disability insurance (i.e. WCB/WSIB/CSST, Union Disability Benefit, Creditor, Credit Cards, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Auto Insurance | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other Group/Association/Individual Plans | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Employment Insurance | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Quebec Parental Insurance Plan | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Canada/Quebec Pension Plan | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Employer Disability, Severance or Retirement | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Any other Accident/Group/Association/Government Disability Benefit | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other (specify) i.e. in Quebec, Criminal Victims Benefits | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

6 Your declaration and authorization

Fraudulent claims are costly for you and your plan sponsor. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

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 use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I agree that Sun Life Assurance Company of Canada and my Plan Sponsor may share financial information related to my claim for purposes relevant to the management of the Plan. I understand that information about me pertaining to this claim may be reviewed in the event this Plan is audited.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to exchange information about me, **except** for details relating to diagnosis, treatment or medication, that is relevant to this claim for the purpose of planning and managing my rehabilitation and return to work.

| | |
|-------------------------|--------------|
| Name (please print) | |
| Member's signature X | Date (d/m/y) |

Please notify Sun Life Assurance Company of Canada and your Plan Sponsor of your expected return to work date.

Please fax or mail to Sun Life Assurance Company of Canada Group Disability Management office.

Vancouver:

Fax: 1 866 639-7829

PO Box 48810 Stn Bentall

Vancouver BC V7X 1A6

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