Claim for accidental dismemberment benefit and loss of use: Employer's statement

Sun Life Financial

Keeping Your Information Confidential

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers and reinsurers who, in some instances, may be located in jurisdictions outside Canada. Your personal information may be subject to the laws of those foreign jurisdictions. Sun Life Financial's operations worldwide and our third-party providers 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.

Please PRINT clearly.

1 Employer's statement

Employee's first name	Last name

Contract number	Subdivision	Member ID number

Take the following information from your enrolment card for this employee.

Employee's background

Employee's present classification	Date this classification became effective (dd-mm-yyyy)	If insurance has been cancelled, give date (dd-mm-yyyy)

If insurance has been cancelled, give reason

Annual salary at last date worked	Amount of insurance at date last worked	Date employee last worked (dd-mm-yyyy)
$	$	

If not actively at work, please provide reason

Is this claim due to an Occupational injury?	Is this claim being made for Workers' Compensation?
☐ Yes ☐ No	☐ Yes ☐ No

Give any additional information which might assist the Company in considering this claim.

2 Policyholder's signature

Name of policyholder			
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number

Signature	Title	Date (dd-mm-yyyy)
X		

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1 Employee's statement

Employee's information

First name ☐ Mr. ☐ Mrs. ☐ Ms.	Last name	Contract number	Subdivision	Member ID number

Date of birth (dd-mm-yyyy)	Occupation
– –	

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number
			– –

Accident details

Date of accident (dd-mm-yyyy)	Time of accident ☐ A.M. ☐ P.M.	Where did it occur? ☐ At home ☐ At work ☐ Elsewhere
– –		

How did it occur? (give full particulars)

2 Claimant's authorization

I certify that the statements in this form are true and complete.

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

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

2 Claimant's authorization (continued)

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

Signature	Location signed (city)	Location signed (province)	Date (dd-mm-yyyy)
X			– –

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number
			– –

Note to Claimant

Please have the attached Physician Statement completed by attending physician and submit the completed form to:

Sun Life Assurance Company of Canada
Group Life Claims
1155 Metcalfe St
Montreal QC H3B 2V9

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Please PRINT clearly.

1 Physician's statement

Patient last name	First name

Date of accident (dd-mm-yyyy)	Date you first consulted on account of the injuries from this accident (dd-mm-yyyy)
_ _	_ _

Loss

Did the accident result in the loss of:	Date of loss	Extent of loss	Yes	No
a) ☐ One hand ☐ Both hands	(dd-mm-yyyy) _ _	Was severance at or above wrist?	☐	☐
b) ☐ One arm ☐ Both arms	(dd-mm-yyyy) _ _	Was severance at or above elbow?	☐	☐
c) ☐ One foot ☐ Both feet	(dd-mm-yyyy) _ _	Was severance at or above ankle?	☐	☐
d) ☐ One leg ☐ Both legs	(dd-mm-yyyy) _ _	Was severance at or above knee?	☐	☐
e) ☐ Thumb and index finger on the same hand	(dd-mm-yyyy) _ _	Was severance at or above the metacarpophalangeal joints?	☐	☐
f) ☐ Four fingers on the same hand	(dd-mm-yyyy) _ _	Was severance at or above the metacarpophalangeal joints?	☐	☐
g) ☐ Four toes on the same foot	(dd-mm-yyyy) _ _	Was severance at or above the metacarpophalangeal joints?	☐	☐
h) ☐ All toes on the same foot	(dd-mm-yyyy) _ _	Was severance at or above the metacarpophalangeal joints?	☐	☐
i) ☐ Sight of one eye ☐ Both eyes	(dd-mm-yyyy) _ _	Is loss of sight **total** and **irrecoverable**?	☐	☐
j) ☐ Hearing one ear ☐ Both ears	(dd-mm-yyyy) _ _	Total and irrecoverable.	☐	☐
k) ☐ Speech	(dd-mm-yyyy) _ _	Complete and irrecoverable loss of ability to utter intelligible sounds.	☐	☐

1 Physician's statement (continued)

Loss of use

Did the accident result in the loss of use of:		Date of loss of use	Is loss entire and irrecoverable*?	Yes	No
a)	☐ One hand ☐ Both hands	(dd-mm-yyyy)		☐	☐
b)	☐ One arm ☐ Both arms	(dd-mm-yyyy)		☐	☐
c)	☐ One foot ☐ Both feet	(dd-mm-yyyy)		☐	☐
d)	☐ One leg ☐ Both legs	(dd-mm-yyyy)		☐	☐

Did the accident result in any of the following:				☐ complete ☐ incomplete
☐ Hemiplegia	☐ Paraplegia	☐ Quadriplegia		
Details				

Loss of vision

If injury necessitated removal of eye, please provide date of removal (dd-mm-yyyy)	
Vision in each eye prior to accident Right Left	Present vision, if any, in each eye Right Left

Treatment

Please explain if there are any future plans/testing to determine if any of the use may be restored by: further surgery?
further rehabilitation and/or therapy?

Condition

Did losses occur from bodily injury caused solely by external, violent and accidental means? ☐ Yes ☐ No
If *no*, please give details of any condition or disease which in your opinion may have served as a contributory cause

2 Physician's signature

Physician's name (print)			
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Signature X	Certified specialist		Date (dd-mm-yyyy)