Short-Term Disability
Plan Member Package

How to use this package:

REVIEW	• The links below will take you to the Short-Term Disability (STD) Claim Guide, a Plan Member's Statement and an Attending Physician's Statement included in this package. • The "Return to Introductory Page" link on each document will take you back to this page. • The STD Claim Guide is designed to answer questions you may have regarding the claim submission process. • Read the Authorizations on both the Plan Member's Statement and Part 1 of the Attending Physician's Statement.
COMPLETE	• You are able to save information typed into the forms included in this package. • Complete the Plan Member's Statement in its' entirety. • Complete Part 1 (Plan Member Information) on the Attending Physician's Statement.
PRINT	• Print the complete Plan Member's Statement and sign the Authorization. • Print the Attending Physician's Statement with Part 1 completed, sign the Authorization and have your physician or specialist complete the form in its entirety.
SUBMIT	• Send in your completed forms using one of the options provided on the last page of the Plan Member Statement.

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

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Short-Term Disability

Claim Guide

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Short-Term Disability (STD) coverage provides benefits to you when you are disabled. This guide is designed to help you through the claim submission process and to answer any initial questions you may have with respect to filing a claim for Short-Term Disability benefits. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can.

When we receive your claim. Your Case Manager reviews all the information received about your claim and the contract provisions. As part of this review, they look at:

- the medical information
- the impact your condition has on your ability to function and carry on your daily activities
- your occupational duties
- how your condition affects your ability to perform your occupation

As part of this review, your case manager may contact you by phone to discuss your claim. They may have some questions for you to better understand your condition, but this is also an opportunity for you to ask them any questions you may have about your claim. They may also need to contact your doctor and/or employer to ask some further questions or to obtain any missing information.

We'll let you know. The claims assessment process usually takes 5 business days after we receive all the necessary information. If your claim is approved based on your employer's STD plan, your case manager will notify you and your employer in writing. If your claim is not approved, your case manager will notify you in writing and provide the reasons for the decision.

For some claims, we may determine that we don't have enough information to make an informed decision.

Your information is confidential. We treat the information you provide to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's Statement, or as permitted or required by law.

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Reporting your absence

To apply for STD benefits, you and your employer will need to send us a completed STD form package. The package contains three forms:

- A Plan Sponsor's Statement, which your employer completes and sends to us separately;
- A Plan Member's Statement, which you must complete and return to our office.
- An Attending Physician's Statement, which you take to your doctor to complete.

NOTE: Your doctor may charge you a fee to complete this form. If so, you will be responsible for paying that fee.

Complete the Plan Member's Statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence.
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Provide the required document outlined in the "Automatic deposit of your disability payments" section if you would like to have your payments deposited into your bank account. For chequing accounts, we will require a personalized VOID cheque.
- Read and sign the Authorization which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. Also, please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.

Have your physician complete the Attending Physician's Statement

This statement provides us with specific medical information about your condition and your expected recovery.

- The Attending Physician's Statement must include all the information requested about your condition. This form can be completed by your family doctor, a doctor at a walk-in clinic, a specialist or nurse practitioner - any medical professional who is a doctor of medicine and that has treated you for your condition.
- If your doctor has conducted tests, a copy of the findings must be included with the Statement.
- If you have seen a specialist for your condition, be sure to have your doctor send us copies of all consultation and clinical notes with the Statement.

NOTE: Do not change or write anything on the Attending Physician's Statement. Any changes to the Statement must be initialed by your doctor.

Sending in your forms

- Follow up with your doctor (if the form was left with them for completion) and employer to confirm they have completed, signed and submitted their forms to our office.
- We recommend you submit the completed claim forms as soon as possible after the beginning of your absence, as most contracts limit the period of time in which to submit a claim.
- Send in your forms using one of the options provided on the last page of the Plan Member Statement.

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Be sure your group Contract number and your Member ID number are clearly shown on your Plan Member's Statement and Attending Physician's Statement before submitting the forms to us.

If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.

FAQs

We want you to feel comfortable with the Short-Term Disability claims process. This Frequently Asked Questions guide is designed to help you understand more about the process, from claims submission through to your recovery.

What does plan sponsor mean? The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your plan.

What are my Contract and Member ID numbers? The Contract number refers to the document that outlines your plan sponsor/employers benefits plan with Sun Life Financial. The Member ID is the number used to identify you specifically. These numbers can be found on your coverage or enrollment summary or in your employee benefits booklet.

Why does my doctor need to fill out the Attending Physician's Statement? The Attending Physician's Statement has been designed to ask your doctor for information that will help us understand the nature of your condition and how it impacts your functional abilities. If your doctor provides only part of the information requested, or a brief note on a doctor's prescription pad, we may not have all the information needed to assess your request for benefits. This will potentially delay a decision on your claim.

How are my benefits calculated? Disability benefit payments are usually based on a specific percentage of your weekly earnings at the time you become disabled. The benefit amount under your plan is specified in your employee benefits booklet.

If my claim is approved, when do my payments start? Your disability benefit payments will be paid from the day following the completion of the elimination period. The elimination period is outlined in your employee benefits booklet. If this date is in the past, then payment will be made back to this date, for the retroactive amount owing.

How and when are payments made once the claim is approved? If you would like to have your benefits deposited directly into your bank account, the Plan Member's Statement outlines what information is needed in order to set this up - see *Automatic deposit of your disability payments.* Don't forget to review this section and provide the required documentation. For chequing accounts, we will require a personalized VOID cheque. NOTE: There may be a delay in payment if a scheduled payment falls on a holiday.

How long will I receive disability payments? For STD, you will continue to receive disability benefit payments as long as you meet the definition of total disability. Usually, this means you are 'totally disabled' for your own occupation up to the maximum benefit period. The definition of total disability and the maximum benefit period for your plan are defined in your employee benefits booklet. There are also other requirements you must meet in order to continue to receive disability benefit payments. These include continuing to explore new employment opportunities, pursuing appropriate treatment or attempting modified work duties. Please consult your employee benefits booklet for the specific details of your plan.

What are my responsibilities while I receive disability benefits? While you are in receipt of disability benefits, we will talk to you about returning to work, at the appropriate time. We expect that you will participate in these discussions, and return to your own occupation as soon as it is safe and healthy for you to do so. If it becomes apparent that you will not be able to return to your own occupation, you will be expected to consider any reasonable offer of modified work with your employer.

Once I've been approved for benefits, how often is medical information requested? A clear understanding of the progress of your recovery is considered essential in preparing for a potential return to work. Periodic updates on your medical condition and functional status help us determine your progress. The frequency of status reports will be determined by the unique circumstances of your claim, your medical condition and treatment plan. We will follow up with you and your treating doctor(s) by telephone or mail. Your Case Manager will work with your doctor and Sun Life's Health Partners to ensure you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam to get more information. We will arrange the appointment and give you adequate advance notice. (We will provide a copy of the results to your treating doctor.)

When would benefits not be paid? Benefits may not be paid if you:

- are not considered totally disabled
- are not receiving or following appropriate treatment as recommended by your treating doctor
- are not participating in a Sun Life-approved rehabilitation program
- are on leave of absence, strike or lay-off, except where Sun Life specifically agreed to the continuation of coverage or as required by law
- are absent from Canada due to any reason, unless you have received written agreement from our Case Manager in advance to pay benefits during this period
- complete any work for wage or profit except as approved by us
- serve a prison sentence or are confined in a similar institution

Please consult your employee benefits booklet for the specific details of your plan.

What if I receive income from another source? How will that impact my benefit? Your employer's STD plan may indicate that your disability benefit payments are reduced by payments received from other sources, such as Canada Pension Plan (CPP), Quebec Pension Plan (QPP) and Workers' Compensation for the same or subsequent disability. Your benefit payment will not be reduced by income you receive from an individual disability plan. A retroactive award from another source may reduce your disability benefit payments and may result in an overpayment. If this situation occurs, you are expected to reimburse the amount overpaid.

What if I return to work with some restrictions? Your Case Manager will work with you and your employer to develop a return-to-work plan that accommodates what you are able to do. Your return-to-work plan could include, for example, a gradual increase in hours and/or modified duties. Should your return to work require specific vocational expertise, we may involve one of our Health Management Consultants to assist with planning your return to the workplace. We will contact your doctor to ensure he or she is aware of the plan before it begins. Once you're back performing the essential duties of your occupation, full-time, Sun Life is usually no longer involved.

What happens if I'm unable to return to work before the maximum benefit period? If your absence is anticipated to extend beyond the maximum benefit period provided under your employer's STD plan, and you have LTD coverage with us we will rely on the medical information gathered during the management of your STD claim to make a decision on your entitlement to Long Term Disability benefits. Your Case Manager will provide you with further information at that time.

Will I receive a tax slip? A tax slip will be issued if the disability benefit payments you receive are taxable income. Tax slips are mailed by the end of February every year, for the previous tax year. If you are unsure if the disability benefits payments you receive are taxable income, please contact your Benefits Administrator.

* This guide is not intended to replace or amend your employee benefits booklet. If there are any discrepancies between your employee benefits booklet and the information in this guide, the group benefits booklet will take priority.

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than five million people in over 10,000 corporate, association, affinity and creditor groups across Canada. Our core values — integrity, service excellence, customer focus and building value — are at the heart of who we are and how we do business.

Our extensive products, services and technology enable us to tailor group benefit programs to meet virtually any customer's needs competitively and cost effectively.

Sun Life Financial and its partners have operations in key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies. PDF8006-E-04-18 ml-cc

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Sun Life Financial

Plan Member's Statement
Claim for Disability benefits

Sun Life Financial

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

Clear

1 Plan Member information

In order to avoid any delays in the assessment of your Short-Term Disability (STD) and where applicable, Long-Term Disability (LTD) 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 disability benefits under your Short-Term Disability or if applicable, Long-Term Disability Plan are taxable, your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite
City		Province	Postal code
Occupation	Job title	Social Insurance Number	
Home telephone number		Alternate telephone number	
What province were you living in at the time your coverage became effective under this plan?		Preferred language of correspondence ☐ English ☐ French	

If you would like Sun Life Assurance Company of Canada ("Sun Life") to email you, please fill in your email address below. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

Email address

2 Plan Sponsor information

Contract number	Member ID	Company name	
Contact person		Contact person email	Contact person phone number

3 About your illness or injury

You must notify Sun Life if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

1. Please describe your present illness or injury and how it occurred.

3 About your illness or injury (continued)

2. When did your symptoms first appear? Date (dd-mm-yyyy)
3. Have you ever had the same or similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

4. Is your condition related to pregnancy? ☐ No ☐ Yes If yes, what is your delivery date? Date (dd-mm-yyyy)
   Please describe your complications, if any.

5. From what date did your illness or injury prevent you from working? Date (dd-mm-yyyy)
6. Please include a list of the duties of your job that you are unable to do.
7. What treatments are you presently receiving (Medications, physiotherapy, psychotherapy, etc..)
8. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

3 About your illness or injury (continued)

9. When do you expect to be able to return to work? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

10. Have you tried to return to work already? ☐ No ☐ Yes If yes, please answer the following questions.

What were the dates that you returned to work? From Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

Did you return to: ☐ your own job ☐ new job or modified duties

Did you return to: ☐ full-time ☐ part-time

4 Disability as a result of an accident

1. Is your disability the result of an accident?

☐ No If no, continue with the next section "**Your other income**".

☐ Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location

2. Were you working for your employer at the time of the accident? ☐ No ☐ Yes Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident? ☐ No ☐ Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number

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

☐ No If no, explain why you are not taking legal action.

☐ Yes If yes, please complete the following:

Name of lawyer			Telephone number
Address	City	Province	Postal code

On what date did the legal action start? Date (dd-mm-yyyy)

Has a settlement been reached? ☐ No ☐ Yes If 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	Insurance Co. & Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per ☐ Week ☐ Month	When are your benefits expected to end? (dd-mm-yyyy)
		Yes	No	Current	Expected		
Any other disability insurance (i.e. WCB/WSIB/ CNESST, Union Disability Benefit, Creditor, Credit Cards, etc.)		☐	☐	☐	☐	$	
Auto Insurance		☐	☐	☐	☐	$	
Other Group/Association/Individual Plans		☐	☐	☐	☐	$	
Employment Insurance		☐	☐	☐	☐	$	
Quebec Parental Insurance Plan		☐	☐	☐	☐	$	
Canada/Quebec Pension Plan		☐	☐	☐	☐	$	
Employer Disability, Severance or Retirement		☐	☐	☐	☐	$	
Any other Accident/Group/Association/ Government Disability Benefit		☐	☐	☐	☐	$	
Other (specify) i.e. in Quebec, Criminal Victims Benefits		☐	☐	☐	☐	$	

6 Automatic deposit of your disability payments

This service is subject to the approval of your claim.

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque. Please check with your Benefit Administrator to determine if this option is available to you.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

7 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan and we will verify 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 ("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 the STD Plan and, where applicable the LTD 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 both Plans. I understand that information about me pertaining to my claim may be reviewed in the event these Plans are 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.

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 STD plan, and where applicable the LTD 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.

Member's last name (please print)	First name	
Member's signature X		Date (dd-mm-yyyy)

8 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.

If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.

You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to *disabilityclaims@sunlife.com*. Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:
Fax: 1-866-639-7850
PO Box 11480 Stn CV
Montreal QC H3C 5P5

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

Edmonton:
Fax: 1-866-639-7820
PO Box 2733 Stn Main
Edmonton AB T5J 5C9

Toronto:
Fax: 1-866-639-7851
PO Box 950 Stn A
Toronto ON M5W 1G5

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

9 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Attending Physician's Statement Disability Claim

Sun Life Financial

Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada ("Sun Life") in making a decision on your patient's claim for disability benefits.

The term "claim" as used throughout this statement relates to the assessment of the plan member's absence from work under the Short-Term Disability (STD) plan and where applicable, the member's absence from work under the Long-Term Disability (LTD) plan.

Return address

Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

Edmonton:	Toronto:	Halifax:	Montreal:	Kitchener - Waterloo:	Vancouver:
Fax: 1-866-639-7820	**Fax: 1-866-639-7851**	**Fax: 1-866-639-7850**	**Fax: 1-866-639-7846**	**Fax: 1-866-209-7215**	**Fax: 1-866-639-7829**
PO Box 2733 Stn Main	PO Box 950 Stn A	PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Montreal QC H3C 5P5	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6

1 Plan Member information and authorization to be completed by patient

Last name	First name	Home telephone number	Alternate telephone number

Address (street number and name)	Apartment or suite

City	Province	Postal code

Plan Sponsor name	Contract number	Member ID number

Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

I authorize my doctor to collect, use and disclose my personal information to Sun Life, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, 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.

Member's signature	Date (dd-mm-yyyy)
X	

2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Section 2 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete all sections in full.

Diagnosis

Primary:

Secondary:

If childbirth: expected or actual delivery date (dd-mm-yyyy) ☐ Vaginal ☐ C-Section

Occupational illness/injury Is condition arising from employment? ☐ Yes ☐ No

Start dates of current work absence

Date of first visit during current period of absence (dd-mm-yyyy) _____

First date of work absence due to condition (dd-mm-yyyy) _____

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2 Attending Physician's Statement (continued)

Hospitalization

Has your patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy) _____

Have they had day surgery? ☐ Yes ☐ No Date discharged (dd-mm-yyyy) _____

Name of institution: _____

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy) _____ Description _____ Type of anaesthetic _____

Treatment (Drug, dosage, physiotherapy, other)

Prognosis – Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) _____

Visits – Frequency of visits ☐ Weekly ☐ Monthly ☐ Other _____

Symptoms – Describe current symptoms, severity and frequency.

Investigations – Please attach copies of all relevant:

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Please note that Genetic testing information is not required , so please do not include.

Are tests/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy) _____

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit (dd-mm-yyyy) _____

Restrictions and limitations – Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

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4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

<table>
<tr><td>Last name of attending physician (please print)</td><td>First name</td><td colspan="2">Certified specialist</td><td rowspan="4">Physician's stamp</td></tr>
<tr><td colspan="4">Address (street number and name)</td></tr>
<tr><td colspan="2">City</td><td>Province</td><td>Postal code</td></tr>
<tr><td>Telephone number</td><td colspan="3">Fax number</td></tr>
<tr><td colspan="4">Physician's signature
X</td><td>Date signed (dd-mm-yyyy)</td></tr>
<tr><td colspan="5">NOTE: Your patient is responsible for any charge made for the completion of this form.</td></tr>
</table>