Plan Sponsor's Statement
Claim for Long-Term Disability benefits

Sun Life Financial

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

Part 1: Employment and coverage information

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1 Plan Member information

Sun Life Assurance Company of Canada must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety and submit it at least 8 weeks before the end of the elimination period in order to avoid delays.

First name	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Home telephone number	Alternate telephone number		
Regular occupation title/Job name			

2 Plan Sponsor information

Contract number	Sub./Class	Member ID	Division/Billing group number
Company name			
Address (street number and name)			
City		Province	Postal code
Contact person			
Contact's telephone number	Ext.	Email address	

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Dates that pertain to the absence from work due to the current disability.

Date member started with the company (dd-mm-yyyy)	Last date of full-time duties/hours (dd-mm-yyyy)	Last date of modified work (if applicable) (dd-mm-yyyy)

Was the member's employment terminated? ☐ No ☐ Yes If *yes*, on what date? Date (dd-mm-yyyy)

To the best of your knowledge, why did the member stop working?

3 Employment information (continued)

Date member returned to full-time duties (dd-mm-yyyy)	Date member returned to modified work (dd-mm-yyyy)
If applicable, please describe modifications	

Employment class (check all that apply)

- ☐ Full-time
- ☐ Part-time
- ☐ Permanent
- ☐ Contract
- ☐ Temporary
- ☐ Seasonal
- ☐ Hourly
- ☐ Salaried
- ☐ Commissioned
- ☐ Union

What is the regular number of hours per week? _____

Is the member involved in shift work? ☐ No ☐ Yes If *yes*, provide details of the actual rotation schedule for the three months prior to the disability date and the planned schedule for the claimed disability period.

4 Coverage information

Original effective date of member's basic LTD coverage (dd-mm-yyyy)	Original effective date of optional LTD coverage (if any) (dd-mm-yyyy)
Effective date of member's basic LTD Coverage with Sun Life (dd-mm-yyyy)	Effective date of member's optional LTD Coverage with Sun Life (dd-mm-yyyy)
Coverage class (if any)	Was the member required to submit evidence of insurability? ☐ No ☐ Yes

1. Has LTD coverage ended? ☐ No ☐ Yes If yes, when? Date (dd-mm-yyyy)
2. Have LTD premiums ended? ☐ No ☐ Yes If yes, when? Date (dd-mm-yyyy)
3. Is Cost of Living Adjustment(COLA) Applicable? ☐ No ☐ Yes

Please complete in reference to Group Life coverage

Is the member presently insured for Group Life coverage that provides for "Waiver of Premium" while on disability under any Sun Life Assurance Company of Canada group contract? ☐ No ☐ Yes **If yes, please provide copies of all enrolment cards and/or enrolment forms that the member has signed for all Life benefits.**

Contract number _____ Effective date Date (dd-mm-yyyy)

Type of Group Life coverage (complete only if enrolment cards and/or enrolment forms are not available)

Type of coverage	Amount of coverage	Date coverage first became effective (dd-mm-yyyy)	Date coverage last increased (If applicable) (dd-mm-yyyy)
Basic employee life	$		
Basic dependent life	$		
Optional employee life	$		
Optional spousal life	$		
Optional child life	$		
Optional employee AD&D	$		
Optional spousal AD&D	$		
Optional child AD&D	$		

5 Earnings and benefit information

If the plan member is tax exempt and the benefit is taxable, please provide a copy of the documentation supporting their tax exempt status.

Current annual insured salary (as of the last day worked) (excluding overtime, commissions and bonuses) $		
Average monthly commissions earned in the last 24 months. $	If applicable, please provide a copy of the tax information slips issued for the past two years for this commissioned member.	
Total personal income tax exemptions according to the last TD1 form (Federal) $	Total personal income tax exemptions according to the last TP-1015-3V form (Quebec residents only) $	Social Insurance Number

1. Is the plan under which this member is covered taxable? ☐ No ☐ Yes
   If yes, please provide the Social Insurance Number above for the member as it is required for the issuance of the applicable tax information slip(s).
2. Did the member have any scheduled vacation days after the last day worked? ☐ No ☐ Yes
   If yes, how many days? _____
3. Does the member have unused sick leave? ☐ No ☐ Yes If yes, how many days? _____
4. Up to what date was (or will) the member's salary be paid? Date (dd-mm-yyyy)
5. Does the member currently receive remuneration from you? ☐ No ☐ Yes If yes, answer a) and b) below.
   a) How much? $ per month Does this amount include unused sick leave? ☐ No ☐ Yes
   b) Until what date will remuneration continue (including sick leave credits)? Date (dd-mm-yyyy)
6. According to your records, what is the LTD benefit amount? $ per month
7. To your knowledge, has the member applied for any disability/retirement benefits from CPP, QPP or any other government sponsored plan? ☐ No ☐ Yes
   If yes, select benefit type: ☐ Disability ☐ Retirement
8. Does the member belong to a retirement or superannuation plan?
   ☐ No ☐ Yes If yes, Registration number
9. Is the member eligible for early retirement pension? ☐ No ☐ Yes If yes, give details below.

   ☐ **reduced pension** On what date? Date (dd-mm-yyyy) Amount $
   Has the member applied? ☐ No ☐ Yes

   ☐ **unreduced pension** On what date? Date (dd-mm-yyyy) Amount $
   Has the member applied? ☐ No ☐ Yes

   ☐ **medical pension** On what date? Date (dd-mm-yyyy) Amount $
   Has the member applied? ☐ No ☐ Yes

6 Workers' Compensation

1. If the member's illness or injury is work related, have they applied for Workers' Compensation benefits?

☐ No ☐ Yes If yes, please continue.

What is the claim number? | How much is the benefit per month? $

What is the effective / first payment date? Date (dd-mm-yyyy)

2. Has the member received a permanent disability award?

☐ No ☐ Yes If yes, when did they receive it? Date (dd-mm-yyyy)

Was it a monthly benefit? ☐ No ☐ Yes If yes, what was the amount? $

Was it a lump sum settlement? ☐ No ☐ Yes If yes, what was the amount? $

3. If the member's claim has been denied or terminated, have they appealed the decision?

☐ No ☐ Yes If yes, when did they appeal it? Date (dd-mm-yyyy)

Please indicate the stage of the member's appeal (if known).

☐ Oral ☐ Board of review ☐ Medical panel ☐ Medical review ☐ Other _____

7 Declaration for Part 1

I certify that the statements in Part 1 of this form are true and complete.

Last name of person signing this statement (please print)	First name	Position
Authorized signature X		Date (dd-mm-yyyy)
Telephone number	Fax number	

Part 2: Information about the member's disability and job

1 Plan Member information

First name	Last name	
Date of birth (dd-mm-yyyy)	Contract number	Member ID

2 Information about the disability and rehabilitation

Attach extra sheets, if necessary.

This section asks for information on the member's specific job duties. This part should be completed by the member's immediate supervisor. If there is a prepared job description, please attach it to this form.

1. From your observations did the member's ability to perform his or her job change?

2. When did the member's illness or injury first appear to affect his or her work? Date (dd-mm-yyyy)

3. Were any changes made in the member's job as a result of the illness or injury?

☐ No ☐ Yes If yes, what were the changes and when were they made?

4. Are modified duties available? ☐ No ☐ Yes

Have modified duties been offered? ☐ No ☐ Yes If yes, please describe duties (part-time/full-time/modified).

Did the member accept modified duties if offered? ☐ Yes ☐ No If no, please provide details below.

3 Recent job history

1. On the last day worked, what was the member's:

Job title	Occupation

2. How long has the member worked in this position? Years | Months

3. How many hours per week was the member scheduled to work as of their last day worked? hours per week

3 Recent job history (continued)

4. If the member changed occupations or assignments during the 12 months immediately before the last day worked, describe the previous occupation or assignment, give reason for the change and the effective date of the change.

5. Has the member been absent from work due to sick leave, maternity/parental leave or lay-off during the 12 months before the disability began?

☐ No ☐ Yes If yes, please provide dates and details.

Type of leave	Details	Beginning date (dd-mm-yyyy)	End date (dd-mm-yyyy)

4 Work environment and job activities

If there is a prepared job description or physical demands analysis for the member's job, please include it with this form.

1. Does the plan member's job require work in any of the following conditions:

Outside	☐ No	☐ Yes	If yes, what percentage of time?	%
In extremes of cold or heat	☐ No	☐ Yes	If yes, what percentage of time?	%
In a damp or humid environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a noisy environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a dusty or unventilated environment	☐ No	☐ Yes	If yes, what percentage of time?	%
Around toxic fumes	☐ No	☐ Yes	If yes, what percentage of time?	%

2. Does the plan member's job involve handling chemicals? ☐ No ☐ Yes If yes, please list the chemicals below.

3. During the plan member's normal routine, what percentage of time does the job require the member to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
More than 50 lbs/22.7 kg	☐	☐	☐	☐	☐
More than 20 lbs/9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs/4.5 kg	☐	☐	☐	☐	☐

4 Work environment and job activities (continued)

4. During the plan member's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

5. How much time is the plan member required to maintain the following activities before changing position or activity?

	0 to 30 minutes	30 to 60 minutes	60 to 90 minutes	More than 90 minutes
Sitting at one time	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐

6. During the average day, what is the number of hours the plan member spends in the following positions or activities?

	0 to 2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Driving	☐	☐	☐	☐

7. Please list any machines, tools, or other equipment that the plan member uses on the job. You can either list the number of times per day the equipment is used or the percentage of time spent using the equipment, whichever is more applicable.

Type of equipment	Number of times per day OR Percentage of time

8. Cognitive/non-physical aspects of the job

Does the plan member have to answer complaints? ☐ Yes ☐ No

Is the plan member primarily evaluated on production? ☐ Yes ☐ No

Does the plan member work closely with co-workers? ☐ Yes ☐ No

Is the plan member responsible for the performance objectives/decision–making within his/her particular department? ☐ Yes ☐ No

Number of people this plan member supervises: ☐

What percentage of the plan member's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

4 Work environment and job activities (continued)

Please list any other relevant aspects of the job that may be considered stressful.

Please indicate if there are any known workplace issues.

5 Additional remarks

Please provide any additional information that may be relevant to this claim which has not been previously provided.

6 Declaration for part 2

I certify that the statements in Part 2 of this form are true and complete.

Last name of person signing this statement (please print)	First name	Position

Authorized signature	Date (dd-mm-yyyy)
X	

Telephone number	Fax number

If you have access to our Group Benefits Absence & Disability web portal, you can submit completed forms electronically through the portal.

Alternatively, please fax this form, along with any other information in support of the plan member's claim, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

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

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