Salary Continuance Services

Plan Member Package

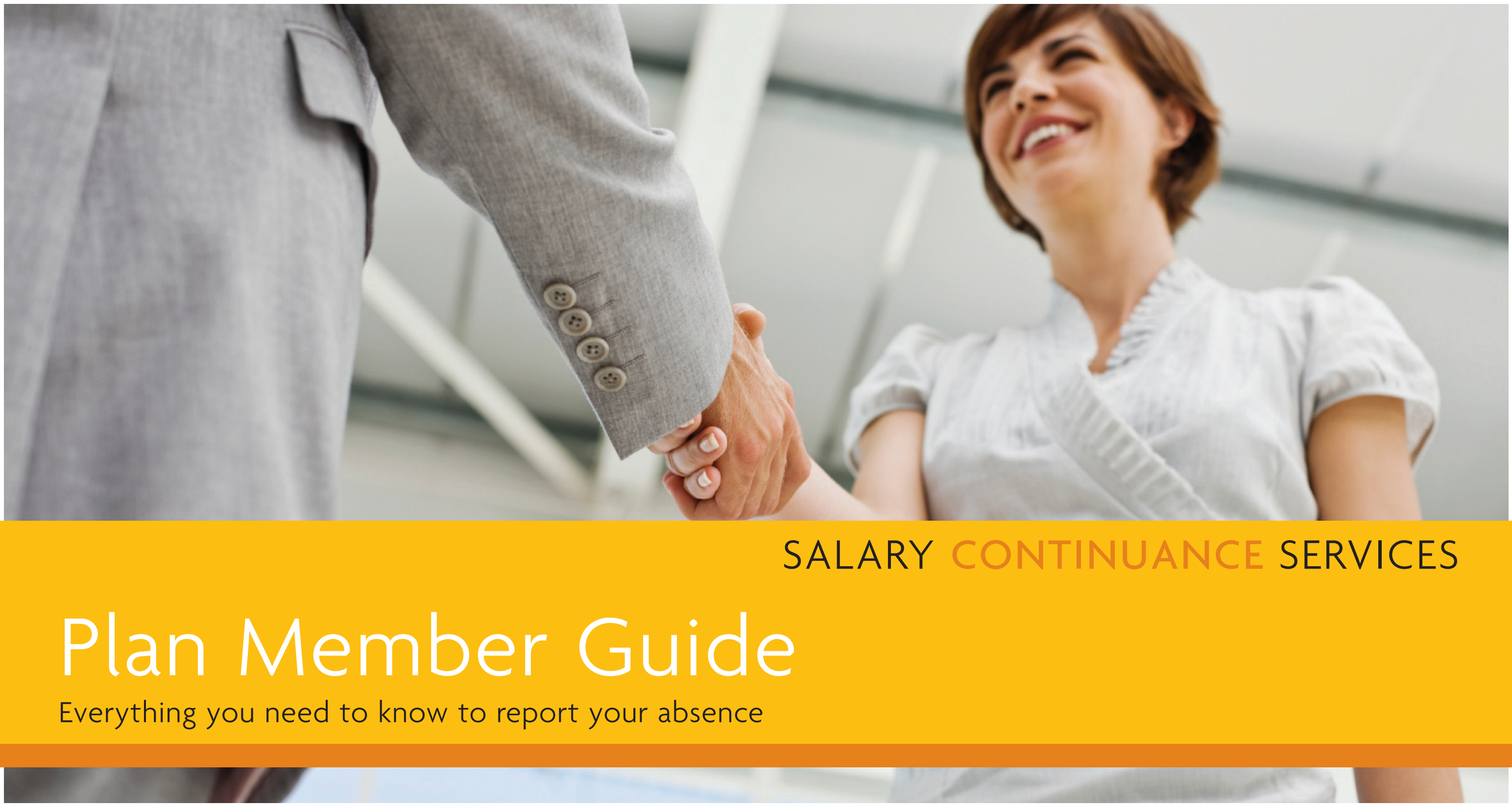
How to use this package:

REVIEW	• The links below will take you to the Salary Continuance Services Plan Member 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. • 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) of the Attending Physician's Statement.
PRINT	• Print the completed Plan Member's Statement (pages 6 - 9) and sign the Authorization. • Print the Attending Physician's Statement (pages 10 - 11) with Part 1 completed, sign the Authorization and have your physician or specialist complete the form in its entirety.
SUBMIT	• Fax the forms, along with any other information in support of your absence that you would like to submit, to the number that appears on the forms for the Sun Life Group Disability Management office that manages your absences. You do not need to mail information that you fax. Please retain the original copy for your records. • Alternatively, you can mail your information to the appropriate office. • If you are not sure which office to send your information to, please contact your Benefits Administrator.

- Salary Continuance Services – Plan Member Guide
- Plan Member's Statement for Salary Continuance Services
- Attending Physician's Statement for Salary Continuance Services

Life's brighter under the sun

Sun Life Financial



SALARY CONTINUANCE SERVICES

Plan Member Guide

Everything you need to know to report your absence

Welcome

Your employer has asked us to help you through the process of reporting your absence, applying for salary continuance and making plans for returning to work. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can. While you'll have support from your doctor, your employer and Sun Life, the most important person involved is you!

Sun Life Financial and your employer want to help you return to health and work as soon as it is safe for you to do so. You probably have lots of questions: this guide will answer many of them and, later on, your Abilities Case Manager will be glad to answer any others as you go along.

To report your absence and apply for salary continuance while you're off work, you and your employer will need to send us the following completed statements:

- **A Salary Continuance Services Plan Sponsor's Statement**, which your employer completes and faxes to us.
- **A Salary Continuance Services Plan Member's Statement** (enclosed with this guide), which you must complete and fax or mail to us. The Sun Life fax numbers and addresses are shown on the form.
- **Attending Physician's Statement** (enclosed with this guide), which you take to your doctor to complete and fax to us. **NOTE:** If your doctor charges you a fee to complete this form, you will be responsible for paying the fee.

The salary continuance plan is provided by your employer with case management services provided by Sun Life.

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Reporting your absence

1. **Complete and fax your 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, and include a detailed job description and résumé with previous job experience and education history. You can attach extra paper to the statement if you need more space.
- 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.
- Please read and **sign the Declaration and Authorization** which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. This is necessary for us to advise your employer if your absence is supported for salary continuance.
- Please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.
- Fax us your completed Plan Member's Statement within the time set by your plan sponsor in their absence policies and procedures. If you're unsure of how much time you have, ask your manager.

2. **Have your physician complete the Attending Physician's Statement**

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

- Your doctor's Attending Physician's Statement must provide a diagnosis and prognosis for your condition. This form can be filled out by your family doctor, a doctor at a walk-in clinic, a specialist, etc. – any medical professional who is a doctor of medicine and who has treated you for your condition.
- If your doctor conducts tests, all of the findings must be included on or with the Statement.
- If your absence is due to a **mental health condition**, be sure to have your physician send us copies of all consultation and clinical notes with his or her Statement. Often, we must follow up to request these documents which can delay the assessment of your absence.
- Follow up with your doctor and employer to confirm they have completed, signed and faxed us their Statements (Plan Sponsor, Plan Member and Attending Physician).

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

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

Salary continuance

An Abilities Case Manager will be assigned to you once we receive your Plan Member's Statement and your employer's Plan Sponsor's Statement. He or she will assess the information we receive about your absence, including the medical information, information about your ability to function and carry on daily living activities, your job demands, your work environment, etc. We may need to contact you, your doctor and/or your employer by phone or in person to ask questions or obtain any missing information. Once the assessment is complete (usually about five business days after we receive all the necessary information), your Abilities Case Manager will write to you and your employer to confirm that:

- Your absence is medically supported, based on the information submitted; or
- Your absence is not medically supported, based on the information provided; or
- The information provided is not sufficient for us to assess whether your absence is medically supported, and we will ask you to provide further information.

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What happens next?

If your absence is medically supported during the salary continuance period, we will continue to monitor your condition while you are away from work. We will ask you for medical updates from your doctor from time to time (frequency will depend on your medical condition, treatment plan, progress, etc.). And you will be expected to follow your doctor's treatment advice as well as our return-to-work plan if one is presented to you.

Your information is confidential

We treat the information you provide us as confidential. We will use the information for the initial and ongoing assessment of your absence. It will not be shared with other parties, including your employer, without your written consent.

We will only advise your employer about limitations or restrictions that affect your ability to do your job (as outlined in the Acknowledgment you signed on your Plan Member's Statement).

FAQs

We want you to feel comfortable with the salary continuance absence submission process. The following Frequently Asked Questions are designed to help you understand more about the process, from absence submission through to your recovery and return to work.

What do 'plan sponsor' and 'plan member' mean?

The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your health benefits plan. The 'plan member' is another name for the employee.

What are my Contract, Division and Member ID numbers?

The Plan Member's Statement asks for your Contract number, Member ID and Division/Billing number. The Contract and Division numbers are specific to your plan sponsor/employer's coverage with Sun Life Financial. The Member ID number is the number used to identify you specifically. These numbers can be found on your coverage card and should be added to your forms by your plan sponsor. If you are unsure, please contact your Benefits Administrator.

Why should my doctor fill out all the information on my form?

To quickly assess your absence, it is very important to have all of the information requested. If your doctor provides only part of the information, or a note on a doctor's prescription pad, we will likely not have all of the information needed to assess your request for benefits, or an extension of benefits. This will potentially delay a decision about your absence.

Can Sun Life stop my salary continuance?

Sun Life cannot stop your salary continuance directly, but we will advise your employer whether your absence from work is medically supported. If the information we receive from you, your plan sponsor, and your physician does not show that you are unable to perform the essential duties of your job, or if you don't provide medical information to support your absence, our advice to your employer may be that your application for salary continuance should not be supported.

Can Sun Life tell me what treatment to have if I'm ill or injured?

No. Sun Life does not tell you what your treatment should be, but we will review your doctor's treatment plan and compare it with generally accepted medical guidelines for your condition. Your Abilities Case Manager will work with your doctor and/or our Health Partners to determine that you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam (IME) through our network of health service professionals across the country, to get more information. We will arrange such an appointment and give you adequate advance notice. We will provide a copy of the results to your treating physician.

Does Sun Life share medical information with my employer?

In most cases, no. Most diagnosis, medication or treatment information obtained by Sun Life concerning your health event is strictly confidential and will not be shared with your employer.

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However, in some cases – such as when an IME is required – your employer may request an update on your medical information so they can continue to support you in your absence by developing a case management plan. In these cases, we will not share any information concerning your diagnosis, medication or treatment without written authorization from you.

How long will I receive salary continuance?

You will continue to receive salary continuance until you return to work or become work-ready (e.g. trained for another occupation), are medically able to return to work, or until you reach the end of the Long Term Disability waiting period (when you may begin receiving Long Term Disability benefits and your salary continuance will end).

Can I be forced to go back to work if my doctor says I can do light-duty work?

If your doctor approves your return to light-duty work and appropriate work is available for you, you may be required to return to work and perform that job.

What if I return to work with some restrictions?

Your Sun Life Health Management Consultant and your employer will work with you to develop a return-to-work plan that accommodates your restrictions. Your return-to-work plan could include, for example, graduated return to work with modified or part-time duties to help you adjust. Your Abilities Case Manager will likely contact your doctor to ensure he or she agrees with the plan before it begins.

Once you're back to work full-time without restrictions, Sun Life is usually no longer involved.

What if I'm still off work when my salary continuance runs out?

If you are still unable to return to work and are approaching the end of your salary continuance, we will contact you to start the application process for long term disability benefits. It is best to begin this process about eight weeks prior to the end of your salary continuance. We will provide further instructions if and when that time comes.

What happens when I want to return to work?

Your Abilities Case Manager will work with you ensure your employer knows you're ready to return to work.
They will update your file and report to your manager.

NOTE: If you return to work but are absent again for the same or related reasons within 14 calendar days of your return, your second absence will be considered a continuation of the earlier absence so you won't have to complete another 'waiting period' before qualifying for salary continuance. It will also impact the length of time it would take you to qualify for Long Term Disability if you remained absent from work.

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Plan Member's Statement
Salary Continuance Services

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 absence, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this absence will be your responsibility.**

First name	Last name (Quebec residents – maiden name)	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite
City	Province	Postal code	
Occupation	Job title		
Home telephone number	Alternate telephone number	Email address	

2 Plan Sponsor information

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

3 About your illness or injury

You must notify Sun Life Assurance Company of Canada 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.

When did your symptoms first appear? Date (dd-mm-yyyy)

Have you ever had the same or similar illness or injury? ☐ No ☐ Yes
If yes, please explain and give dates.

On what date did you first see a doctor for this illness? Date (dd-mm-yyyy)

Please describe your present illness or injury and how it prevents you from working. Include a description of which duties of your job you are *unable* to perform because of your illness or injury. As well, list the duties of your job you *are* able to perform. (Attach extra sheets, if necessary.)

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3 About your illness or injury (continued)

When was your last day of full-time duties/hours?

Date (dd-mm-yyyy)
– –

When was your last day of modified work (if applicable)?

Date (dd-mm-yyyy)
– –

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

Date (dd-mm-yyyy)
– –

During this period, have you worked at any occupation or employment? ☐ No ☐ Yes If yes, please explain.

What are the current symptoms preventing you from working?

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.

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 declaration and authorization**".
   ☐ 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? ☐ Yes ☐ No 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 – –

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5 Your declaration and authorization

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 absence(s) from work. I authorize Sun Life to collect, use and disclose information needed for administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan ("this Plan") to any person or organization who has relevant information pertaining to my absence(s) from work 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 absence(s) from work for purposes relevant to the management of this Plan. I understand that information about me pertaining to my absence(s) from work may be reviewed in the event that this Plan is audited.

I authorize Sun Life to collect from and discuss with my Plan Sponsor any information in my Plan Sponsor's file (including diagnosis, treatment or medication) pertaining to my absence(s) and to use such information for the purposes described in the paragraph above.

I also authorize Sun Life and my Plan Sponsor to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **except** for details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I also authorize Sun Life and my Plan Sponsor's medical consultants to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purpose of facilitating in the resolution of any litigation or any other formal legal proceeding (threatened or actual) relating to my absence(s) from work that I may raise or commence against my Plan Sponsor.

I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work 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.

Any reference to Sun Life or my 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	Date (dd-mm-yyyy)
X	– –

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

To ensure prompt submission, please fax this form, along with any other information in support of your absence that you would like to submit, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your absences. 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. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Visit our website:
www.sunlife.ca/ health and work

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

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

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

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

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

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

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6 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, 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.

Attending Physician's Statement
Salary Continuance Services

Sun Life Financial

Purpose of Statement This Statement is to assist Sun Life Assurance Company of Canada in assessing your patient's absence from work.

Return address Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Assurance Company of Canada 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 (Quebec residents – maiden 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 information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan (the "Plan"). I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work 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
X

Date (dd-mm-yyyy)

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 Page 1 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 Pages 1 and 2 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)

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

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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**

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)

4 Attending Physician's acknowledgement

I acknowledge that the information in this Statement will be kept in a group disability absence file with Sun Life Assurance Company of Canada 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.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address			
Telephone number	Fax number		
Physician's signature X		Date signed (dd-mm-yyyy)	

NOTE: The patient is responsible for any charge made for the completion of this form.

Canadian Life and Health Insurance Association Inc. Association canadienne des compagnies d'assurances de personnes inc.

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