Attending Physician's Statement
Short-Term Disability Claim

Sun Life Financial

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

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.

Clear

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 my personal information to Sun Life Assurance Company of Canada, 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 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

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 benefits 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.