

Attending Physician's Statement Short-Term Disability Claim



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.

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

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

Kitchener - Waterloo:

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

Vancouver:

Fax: 1-866-639-7829
PO Box 48810 Stn Bentall
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 a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.

Member's signature X	Date (dd-mm-yyyy) — —
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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 end of the 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 pertaining to this illness (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.

Name of attending physician (please print)		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.