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

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

1 Member information

In order to avoid any delays in the assessment of your 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 the Plan Sponsor pays any portion of the premium, the plan is taxable. Your Social Insurance Number is required for issuance of T4As.

Contract Number	Member ID	Date of Birth (d/m/y)

Name - first and last name (Quebec residents - maiden name)	☐ Male ☐ Female

Address (street number and name, apartment or suite)

City	Province	Postal Code

Occupation	Job Title	Social Insurance Number	Daytime Telephone Number
			( )

2 Plan Sponsor information

Company Name	Division Number

Street Address

City	Province	Postal Code

Contact Person	Contact's Telephone Number	Ext.
	( )	

3 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 void cheque** or for a savings account, please provide the following account details. Please check with your Benefits Administrator to determine if this option is available to you.

This box is for a **savings account only**. The account details should be validated by a bank representative.

Bank Name

Address

Bank Number	Branch Number	Account Number
☐☐☐	☐☐☐☐☐	☐☐☐☐☐☐☐

4 About your illness or injury

When was your last day at work? Date (d/m/y) ____

What is the date you returned or expect to return to work? Date (d/m/y) ____

During this period, have you worked at any occupation or employment? No ☐ Yes ☐ ▶ Please explain.

What are the current symptoms preventing you from working?

Is your condition related to pregnancy?
No ☐ Yes ☐ ▶ What is your delivery date? Date (d/m/y) ____
Please ensure your physician completes the appropriate pregnancy related form.
Please describe your complications, if any.

5 Disability as a result of an accident

Is your illness or injury due to an accident?
No ☐ Yes ☐ ▶ Where did the accident happen? ☐ at home ☐ at work ☐ elsewhere

Date of the accident Date (d/m/y) ____ Time of the accident ____ a.m. p.m.

Were you working for your Plan Sponsor 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 ☐ ▶ Please enclose a copy of the accident report.

Name of insurance adjuster	Auto Carrier Number	Telephone number
		( )

If your disability is the result of an accident, are you taking legal action against any other person or organization?
No ☐ ▶ Explain why you are not taking legal action.

Yes ☐ ▶ Please complete the following:

Name of Lawyer		
Address		Telephone number ( )
City	Province	Postal Code

On what date did the legal action start? Date (d/m/y) ____

Has a settlement been reached? No ☐ Yes ☐ ▶ Please attach a copy of the terms of the settlement.

6 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	Are you eligible for this benefit? Yes	No	Insurance Co. & Policy Number	Have you applied for this income? Yes	No	Are you receiving or do you expect to receive this income? Current	Expected	Amount per ☐ Week ☐ Month
Any other disability insurance (i.e. WCB/WSIB/CSST, 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	☐	☐		☐	☐	☐	☐	

7 Your declaration and authorization

Fraudulent claims are costly for you and your plan sponsor. As Administrator of this plan, we may check 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 may investigate this claim. I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I agree that Sun Life Assurance Company of Canada and my Plan Sponsor may share financial information related to my claim for purposes relevant to the management of the Plan. I understand that information about me pertaining to this claim may be reviewed in the event this Plan is audited.

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.

I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to exchange information about me, **except** for details relating to diagnosis, treatment or medication, that is relevant to this claim for the purpose of planning and managing my rehabilitation and return to work.

Name (please print)	
Member's signature X	Date (d/m/y)

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

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

Please fax or mail to the Sun Life Assurance Company of Canada Group Disability Management office that manages your claim. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:
Fax: 1 866 639-7850
1100 - 1809 Barrington St
Halifax NS B3J 3K8

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