Attending Physician's Statement
Short-Term Disability: General *SunAdvantage*

Sun Life Financial

Member Authorization

This section must be completed and signed by the member to authorize release of medical information.

Contract Number	Member ID	Name - first and last name (Quebec residents - maiden name)	Date of birth (d/m/y)

I authorize my doctor to use and exchange information with 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 or electronic version of this authorization is as valid as the original.

Member's signature	Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

Is patient's condition due to injury or sickness caused by work? ☐ Yes ☐ No ☐ Unknown	Last day at work (d/m/y)	Date of initial visit (d/m/y)	Expected duration of disability

Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Date and nature of surgery (d/m/y)	Type of anaesthetic

Patient referred to you? ☐ Yes ☐ No	Name of referring physician	Have you referred patient? ☐ Yes ☐ No	Name of physician(s)/other

Date of first and all subsequent visits during present period of absence from work (d/m/y)	Date first unable to work because of disability (d/m/y)	Is patient competent to endorse cheques? ☐ Yes ☐ No

Any cost for information to substantiate this claim will be the member's responsibility.

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Diagnosis

Primary	Secondary

History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression

Treatment Plan

List medications, dosage frequency and physiotherapy

Remarks

Please note any psychological or social difficulties which may delay recovery

Prognosis

Please note any restrictions and/or limitations, and state prognosis

If Cardio-related

Canadian Cardiovascular Class OR	American Heart Association Class	*If class 3 or 4, please enclose a copy of the report of the graded exercise test*	Physical findings BP Weight

Rhythm description	Angina (frequency, severity, patterns)

Complications (e.g. cerebral vascular, peripheral vascular or diabetic conditions)

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:

Investigations

Please enclose copies of all relevant reports which objectively support the claimed disability described above (e.g. x-rays, myelograms, C.T. scans, bone scans, etc.)

Name of attending physician (please print)	Specialty	Telephone	Fax

Address

Physician's signature	Date (d/m/y)

Return this form to your patient or send the form to Sun Life Assurance Company of Canada Disability Management office. If you fax or mail the form to Sun Life Assurance Company of Canada, please confirm the appropriate Disability Management office with your patient. Than you for your assistance.Please fax or mail to our nearest Sun Life Assurance Company of Canada Group Disability Management office:

If you live in the Atlantic provinces, Quebec or Ottawa

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

If you live in Ontario except Ottawa

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

If you live in the Prairie provinces, British Columbia or the Territories

Edmonton:
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Attending Physician's Statement
Short-Term Disability: Psychiatric *SunAdvantage*

Sun Life Financial

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Member's signature	Date (d/m/y)

1 General Information

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Please use DSM-IV terminology, including multi-axial assessment and general assessment of function GAF

Is patient's condition due to injury or sickness caused by work? ☐ Yes ☐ No ☐ Unknown	Last day at work (d/m/y)	Date of initial visit (d/m/y)	Expected duration of disability

Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Date and nature of surgery (d/m/y)	Type of anaesthetic

Patient referred to you? ☐ Yes ☐ No	Name of referring physician	Have you referred patient? ☐ Yes ☐ No	Name of physician(s)/other

Date of first and all subsequent visits during present period of absence from work (d/m/y)	Date first unable to work because of disability (d/m/y)	Is patient competent to endorse cheques? ☐ Yes ☐ No

Diagnosis

Axis 1 (Primary)	
Axis 2 (Secondary)	
Axis 3	
Axis 4	
Axis 5	
GAF current	lowest in past year

History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression

Treatment Plan

List medications, dosage frequency and psychotherapy
Counselling (first appointment, last appointment, frequency, results)

Remarks

Please note any psychological or social difficulties which may delay recovery

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:

Prognosis

Please note any restrictions and/or limitations, and state prognosis

Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

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Attending Physician's Statement
Short-Term Disability: Pregnancy *SunAdvantage*

Sun Life Financial

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Member's signature	Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

Is patient's condition due to injury or sickness caused by work? ☐ Yes ☐ No ☐ Unknown	Last day at work (d/m/y)	Date of discharge (d/m/y)	Is patient competent to endorse cheques? ☐ Yes ☐ No
Patient referred to you? ☐ Yes ☐ No	Name of referring physician		Expected duration of disability
Have you referred patient? ☐ Yes ☐ No	Name of physician(s)/other		

Date first unable to work because of disability (d/m/y)	Para	Gravida	Expected due date	Age

Date of first and all subsequent visits during present period of absence from work (d/m/y)

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Diagnosis

Primary	Secondary

History

List all symptoms and abnormal physical findings relevant to the complications in this pregnancy. Please note severity, date of onset and progression

	Pre-pregnant weight	Current weight	Height

Treatment Plan

List medications, dosage and frequency

	Date of hospital admissions (d/m/y)		

Prognosis

Please note any restrictions and/or limitations, and state prognosis

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:

Name of attending physician (please print)	Specialty	Telephone	Fax

Address

Physician's signature	Date (d/m/y)

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Attending Physician's Statement Short-Term Disability: Musculo-Skeletal/ Motor Vehicle Accident *SunAdvantage*

Sun Life Financial

Member Authorization

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Member's signature	Date (d/m/y)

1 General Information

This form must be completed by a doctor of medicine.

Is patient's condition due to injury or sickness caused by work? ☐ Yes ☐ No ☐ Unknown	Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Is patient competent to endorse cheques? ☐ Yes ☐ No
Last day at work (d/m/y)	First day patient seen (d/m/y)	Expected duration of disability	
Patient referred to you? ☐ Yes ☐ No	Name of referring physician		
Have you referred patient? ☐ Yes ☐ No	Name of physician(s)/other		
Date of first and all subsequent visits during present period of absence from work (d/m/y)			Date first unable to work because of disability (d/m/y)

Any cost for information to substantiate this claim will be the member's responsibility.

Any information provided by you to Sun Life Assurance Company of Canada regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Diagnosis

Primary	Secondary	
Date symptoms appeared or accident happened (d/m/y)	Has patient had same or similar condition? ☐ Yes ☐ No	If yes, please state when and describe

History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression

Physical Findings

	Weight	Height

If result of motor vehicle accident, give accident date (d/m/y)	Expected return to work date will be in 2 to 3 weeks ☐ Expected return to work date will be in 4 to 6 weeks ☐	Other, please explain

Treatment Plan

List medications, dosage frequency and physiotherapy (please note any psychological or social difficulties which may delay recovery)

Prognosis

Please note any restrictions and/or limitations, and state prognosis

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:

Name of attending physician (please print)	Specialty	Telephone	Fax

Address

Physician's signature	Date (d/m/y)

Please enclose copies of all relevant reports which objectively support the claimed disability described above (e.g. x-rays, myelograms, C.T. scans, bone scans, etc.)

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