

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



SunAdvantage

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies is committed to keeping information concerning this claim 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 the member's 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)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (street number and name, apartment or suite)		
City	Province	Postal Code
Occupation	Social Insurance Number 	Daytime Telephone Number ()

2 Plan Sponsor information

Company Name	Division Number	
Street Address		
City	Province	Postal Code
Contact Person	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 (d/m/y)	Date you returned or expect to return to work (d/m/y)
During this period, have you worked at any occupation or employment?	
What are the current symptoms preventing you from working?	
Is your condition related to pregnancy?	If yes, please advise us of your delivery 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?	If yes, did the accident happen - at home / work / elsewhere?	
Date of the accident (d/m/y)	Time a.m. p.m.	Were you working for your Plan Sponsor at the time of the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Please describe how your illness or injury occurred.		
Is your illness or injury due to a motor vehicle accident? If yes, please enclose a copy of the accident report. <input type="checkbox"/> Yes <input type="checkbox"/> No		
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 ()
City	Province	Postal Code

On what date did the legal action start (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?		Insurance Co. & Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per <input type="checkbox"/> Week <input type="checkbox"/> Month
	Yes	No		Yes	No	Current	Expected	
Any other disability insurance (ie. WCB/WSIB/CSST, Union Disability Benefit, Creditor, Credit Cards, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Auto insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Group/Association/Individual Plans	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employment insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canada/Quebec Pension Plan	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employer Disability, Severance or Retirement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any other Accident/Group/Association/Government Disability Benefit	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify) i.e. in Quebec, Crime Victims Benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 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.

Please fax or mail this form along with any forms you may receive from the member to the Sun Life Assurance Company of Canada Group Disability Management office that manages your claims.

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

Visit our Web site:
www.sunlife.ca/healthandwork