Attending Physician's Statement
Claim for Long-Term Disability Benefits

Sun Life Financial

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

This part of the form should be completed before the physician completes part 2

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

You can mail this form directly to one of our regional claims offices. The office addresses are listed at the end of this form.

Please complete this form in its entirety and return to us as soon as possible. Failure to do so may result in the delay of any payments to the patient.

Member Information

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

1. What was the last date you worked? Date (d/m/y)

Member's authorization & signature

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)

2 Physician's Information

Sun Life Assurance Company of Canada will use the information in this form to determine your patient's eligibility for disability benefits.

We ask that you complete the Attending Physician's Statement as thoroughly as possible. Please be assured that this information, including any medical records submitted in support of this claim, will be treated confidentially.

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.

History

1. What was the date of the patient's first appointment for the claimed disability? Date (d/m/y)
2. What was the date of the patient's latest appointment? Date (d/m/y)
3. How often are the patient's appointments? Weekly ☐ Bi-weekly ☐ Monthly ☐
   Other ☐▶ Please specify:
4. Did you recommend that the patient stop work? No ☐ Yes ☐▶ As of what date? Date (d/m/y)
5. Was the patient's disability caused by an accident? No ☐ Yes ☐▶ If yes, give details and the date of the accident.

6. Describe the pertinent symptoms, their severity, their duration and their impact on the claimed disability (including the patient's ability to work).

7. When did the symptoms first appear? Date (d/m/y)

History (continued)

8. Has the patient ever had a similar or related condition? No ☐ Yes ☐▶ If yes, state when and describe the condition.

9. Is the condition due to injury or illness caused by employment? Unknown ☐ No ☐ Yes ☐▶ If yes, give details.

10. Is the condition due to or related to pregnancy? No ☐ Yes ☐▶ If yes, give date of confinement.

Date (d/m/y)

11. In relation to the patient's job responsibilities and duties, how is the patient restricted or limited by the condition?

Clinical findings

Please describe the physical findings in relation to the claimed disability.

Diagnoses

What are the diagnoses that have led to the disability claim? Please list in order of their importance to the patient's disability and their impact on the claimant. If the condition is psychiatric, use DSM IV terminolgy.

Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the disability being claimed.

Documents required (as applicable)
Copies of all

- investigation reports
- laboratory data
- consultation reports
- hospital admission histories and discharge summaries

Treatment

1. Was the patient hospitalized? No ☐ Yes ☐▶ If yes, give dates.

From Date (d/m/y) To Date (d/m/y)

Treatment (continued)

2. Was surgery performed? No ☐ Yes ☐▶ If yes, give details.

Date	Type of Surgery

3. What medications were given to the patient? Please include name(s), dosage(s) and the dates of any medication changes.

4. Was psychotherapy given? No ☐ Yes ☐▶ If yes, give frequency and duration.

5. Was physiotherapy/chiropractic treatment given? No ☐ Yes ☐▶ If yes, give frequency and duration.

6. What other treatments were given?

7. Please give the names, specialties and appointment dates of all other treating physicians.

Name	Specialty	Appointment Date (d/m/y)

Cardiac (Complete if applicable)

1. What is the functional capacity (American Heart Association)? If class 3 or 4, please include a copy of any stress tests or cardiac echograms.

   Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐
   Class 3 (marked limitation) ☐ Class 4 (complete limitation) ☐

2. What is the latest blood pressure reading for the patient? ☐ /

Return to work plan

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?

   Recovered ☐ Improved ☐ Unchanged ☐ Regressed ☐

2. What is the patient's current status?

   Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined ☐

Return to work plan (continued)

3. Can the patient return to **part-time or modified work?** No ☐ Yes ☐► Please give details about the return-to-work plans for the patient including dates for each step of the plan and expected date of return to work. Please describe any limitations or restrictions in work duties.

4. Is the patient fit for **any other occupation?** No ☐ Yes ☐► Please give details about the return-to-work plans for the patient including dates for each step of the plan and expected date of return to work. Please describe any limitations or restrictions in work duties.

5. Please describe any factors not mentioned above that may affect this patient's ability to return to work, (such as social pressure, stress in the workplace or abuse of medication, alcohol or any other substance).

Cooperation and willingness to return to work

1. Please comment on how cooperative the patient has been with the treatment plan.

2. Please comment on the patient's willingness to work.

Additional information

1. In your opinion, is the patient capable of handling his/her own financial affairs? No ☐ Yes ☐
2. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Medical Consultant? No ☐ Yes ☐
3. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Rehabilitation Specialist? No ☐ Yes ☐

Physician information

Name			
Street Address		Province	Postal Code
City	Tel. No. ( )	Fax No. ( )	
Specialty			

Physician's Signature

Signature	Date (d/m/y)
X	

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. Thank you for your assistance.

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	1100 - 1809 Barrington St.	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Halifax NS B3J 3K8	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6