Waiver of premium claim – Attending physician's statement of disability

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.

Clear

A Physician's information – Waiver of premiums

Group Life Claims will use the information you provide to assess your patient's eligibility for benefits. One aspect of the assessment of the claim is the contract definition of disability which may change at a specified date.

Generally, disability is divided into two categories:

1. **Own Occupation** – unable to perform the essential duties of the occupation in which he/she participated just before the disability started.
2. **Any Occupation** – unable to perform the essential duties of any occupation in keeping with his/her educational background and work experience.

Please ask your patient which definition applies to his/her claim and on what date the definition will change, if any. If your patient is unsure, he/she should contact us.

See application procedure below.

B Physician's application procedure

To ensure the prompt adjudication of your patient's claim, the following information may assist you as you complete the attending physician's statement:

- ☐ to qualify for benefits, there must be clinical findings supporting disability – identify specific signs and symptoms
- ☐ provide specific details of any functional limitations which prevent your patient from performing the essential duties of either his/her own occupation or any other occupation including the severity of any dysfunction
- ☐ include any additional information supporting disability that will facilitate the assessment of the claim including:
  - ☐ a summary of specialists findings
  - ☐ investigative test results
- ☐ complete forms promptly

Sun Life Assurance Company of Canada thanks you for your assistance. If you have additional questions, please contact our office at 1-800-361-2128 (ext. 2304).

C To be completed by patient

Complete first page and give to your physician.

Contract number	Member ID number
Date of birth (dd-mm-yyyy) – –	Social insurance number if different from Cert. no./ID no. (required for income tax purposes)
Last name	First name

D Authorization of patient

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.

Patient's signature X	Date (dd-mm-yyyy) – –

Note: The patient is responsible for obtaining this form and any charges for its completion, unless prohibited by law.

Last name of physician completing this form	First name		
☐ Family doctor ☐ Specialist (indicate specialty)			
Physician's address (street number and name)			Apartment or suite
City/Town	Province	Postal code	Telephone number – –

Waiver of premium claim – Attending physician's statement of disability

Sun Life Financial

To be completed by attending physician

The following information will be used to assess your patient's eligibility for disability benefits. Full and accurate answers expedite adjudication. The patient is responsible for the costs of obtaining medical evidence and the completion of this form, unless prohibited by law.

Please PRINT clearly in ink. Return form to patient (or mail c/o Group Life Claims, 1155 Metcalfe Street, Montreal QC H3B 2V9).

1 Diagnosis

Primary	Symptoms
Secondary	Symptoms
Is the patient receiving or in need of treatment for the use of alcohol or drugs? ☐ Yes ☐ No	
Other contributing factors/complications	

2 History

Date symptoms began or accident happened (dd-mm-yyyy)	Date illness or injury forced cessation of work (dd-mm-yyyy)
Date of first visit (dd-mm-yyyy)	Is this a work-related illness/injury? ☐ Yes ☐ Unknown ☐ No
Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown	
If *yes*, state when and describe condition	
Please provide details of any significant or lengthy illness for which you have treated the patient in the last three years	

3 Clinical findings/Investigations

Date of most recent patient examination (dd-mm-yyyy)	Patient is ☐ right handed ☐ left handed	Height	Weight
Blood pressure	Pulse	Cardiac (if applicable) ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)	

Investigations (e.g., EKGs, x-rays, lab tests, etc.)	**Date performed** (dd-mm-yyyy)	**Summary of results** (attach copies of all available reports)

3 Clinical findings/Investigations (continued)

Are any further investigations planned? ☐ Yes ☐ No
If *yes*, state when and type of investigation

Has your patient been referred to any other physician(s)/specialist(s)? ☐ Yes ☐ No
If *yes*, complete the following chart.

Physician's name and specialty	Date of examination (dd-mm-yyyy)	Findings
	– –	
	– –	
	– –	
	– –	
	– –	

Please use a separate sheet for additional comments

Was your patient hospitalized? ☐ Yes ☐ No	Institution
Date of admission (dd-mm-yyyy) – –	Date of discharge (dd-mm-yyyy) – –

4 Treatment

Frequency of patient visits ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other (specify)	
List current medications prescribed and dosage	
Therapy ☐ Yes ☐ No	
If *yes*, indicate type (e.g. physio, psycho, etc.)	
Frequency of therapy ☐ Daily ☐ _____ X per week ☐ Other _____	Location ☐ Outpatient department ☐ Therapist's office ☐ Home
Surgery ☐ Yes ☐ No	
If *yes*, type of surgery	
Date performed (dd-mm-yyyy) – –	Date planned (dd-mm-yyyy) – –
Any other treatment or future plans for treatment? (specify with dates)	
Summarize patient's response to treatment	

5 Current functional limitations

Function	Degree of limitation: None	Slight	Moderate	Severe	Don't know	
Cognition	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Hearing	☐	☐	☐	☐	☐	
Vision	☐	☐	☐	☐	☐	Visual acuity L: _____ R: _____
Sensation	☐	☐	☐	☐	☐	
Dexterity	☐	☐	☐	☐	☐	
Psychological	☐	☐	☐	☐	☐	Current GAF score: _____
Driving	☐	☐	☐	☐	☐	Time restriction: ☐ min. ☐ hrs.
Walking	☐	☐	☐	☐	☐	Time restriction: ☐ min. ☐ hrs.
Standing	☐	☐	☐	☐	☐	Time restriction: ☐ min. ☐ hrs.
Climbing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	Time restriction: ☐ min. ☐ hrs.
Bending	☐	☐	☐	☐	☐	
Lifting	☐	☐	☐	☐	☐	Maximum recommended weight: _____ ☐ lbs ☐ kgs

For injuries of the shoulder, back and neck, please list limitations on flexion, extension and ROM
Describe any functional limitations, physical or psychological, which you consider to be major obstacles to your patient's ability to work
Were any functional capacity evaluations performed? ☐ Yes ☐ No
If *yes*, state when and type of evaluation

6 Prognosis

Date patient is medically able to return to work at **OWN** occupation	☐ Full-time (dd-mm-yyyy) _ _	☐ Part-time (dd-mm-yyyy) _ _
If patient is medically unable to return to **OWN** occupation, date patient will be able to seek other employment	☐ Full-time (dd-mm-yyyy) _ _	☐ Part-time (dd-mm-yyyy) _ _

Has your patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No
If *yes*, please give details on the back of this form.

Physician's signature X	Date (dd-mm-yyyy) _ _
Please print doctor's name	Phone number _ _