Plan Sponsor's Statement Claim for Disability benefits SunAdvantage™

Sun Life Financial

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

The purpose of this statement is for the assessment of the member's absence from work under the Short-Term Disability (STD) plan and where applicable, the Long-Term Disability (LTD) plan.

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1 Plan Member information

Sun Life Assurance Company of Canada (Sun Life) must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety in order to avoid delays.

First name	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)		Apartment or suite	
City		Province	Postal code
Home telephone number	Alternate telephone number		
Regular occupation title/Job name			

Please also submit the form *Disability Job Demands Questionnaire* if the member is expected to be absent for 4 weeks or more.

2 Plan Sponsor information

STD Contract number	STD Sub./Class	Member ID	STD Division/Billing group number
LTD Contract number	LTD Sub./Class	LTD Division/Billing group number	
Company name			
Address (street number and name)			
City		Province	Postal code
Contact person			
Contact's telephone number	Ext.	Email address	

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Dates that pertain to the absence from work due to the current disability.

Date member started with the company (dd-mm-yyyy)	Last date of full-time duties/hours (dd-mm-yyyy)	Last date of modified work (if applicable) (dd-mm-yyyy)

Was the member's employment terminated? ☐ No ☐ Yes If *yes*, on what date? Date (dd-mm-yyyy)

3 Employment information (continued)

To the best of your knowledge, why did the member stop working?

If the disability is due to pregnancy, has or will the member receive any maternity leave? ☐ No ☐ Yes

Date maternity leave begins (dd-mm-yyyy)	Date maternity leave ends (dd-mm-yyyy)

Date member returned to full-time duties (dd-mm-yyyy)	Date member returned to modified work (dd-mm-yyyy)
If applicable, please describe modifications	

Employment class (check all that apply)

☐ Full-time	☐ Permanent	☐ Hourly	☐ Union
☐ Part-time	☐ Contract	☐ Salaried	
	☐ Temporary	☐ Commissioned	
	☐ Seasonal		

What is the regular number of hours per week? _____

Is the member involved in shift work? ☐ No ☐ Yes If *yes*, provide details of the actual rotation schedule for the three months prior to the disability date and the planned schedule for the claimed disability period.

Are modified duties available? ☐ No ☐ Yes

Were modified duties offered? ☐ No ☐ Yes If *yes*, please describe duties (part-time/full-time/modified)

Did the member accept modified duties if offered? ☐ No ☐ Yes If *no*, please provide details below.

4 Coverage information

Effective date of member's STD coverage (dd-mm-yyyy)	
Original effective date of member's basic LTD coverage (dd-mm-yyyy)	Effective date of member's basic LTD coverage with Sun Life (dd-mm-yyyy)
Original effective date of optional LTD coverage (if any) (dd-mm-yyyy)	Effective date of member's optional LTD Coverage with Sun Life (dd-mm-yyyy)
Coverage class (if any) B	Was the member required to submit evidence of insurability? ☐ No ☐ Yes

1. Has disability coverage ended? ☐ No ☐ Yes If *yes*, when? Date (dd-mm-yyyy)
2. Have disability premiums ended? ☐ No ☐ Yes If *yes*, when? Date (dd-mm-yyyy)
3. Is LTD Cost of Living Adjustment (COLA) Applicable? ☐ No ☐ Yes

4 Coverage information (continued)

Please complete in reference to Group Life coverage

Is the member presently insured for Group Life coverage that provides for "Waiver of Premium" while on disability under any Sun Life Assurance Company of Canada group contract? ☐ No ☐ Yes **If *yes*, please provide copies of all enrolment cards and/or enrolment forms that the member has signed for all Life benefits.**

Contract number _____ Effective date Date (dd-mm-yyyy) _____

Type of Group Life coverage (complete only if enrolment cards and/or enrolment forms are not available)

Type of coverage	Amount of coverage	Date coverage first became effective (dd-mm-yyyy)	Date coverage last increased (If applicable) (dd-mm-yyyy)
Basic employee life	$		
Basic dependent life	$		
Optional employee life	$		
Optional spousal life	$		
Optional child life	$		
Optional employee AD&D	$		
Optional spousal AD&D	$		
Optional child AD&D	$		

5 Earnings and benefit information

If the plan member is tax exempt and the benefit is taxable, please provide a copy of the documentation supporting their tax exempt status.

Current annual insured salary (as of the last day worked) (excluding overtime, commissions and bonuses)
$

Average monthly commissions earned in the last 24 months.
$

If applicable, please provide a copy of the tax information slips issued for the past two years for this commissioned member.

Total personal income tax exemptions according to the last TD1 form (Federal)	Total personal income tax exemptions according to the last TP-1015-3V form (Quebec residents only)	Social Insurance Number
$	$	

1. Is the STD plan under which this member is covered taxable? ☐ No ☐ Yes
2. Is the LTD plan under which this member is covered taxable? ☐ No ☐ Yes
   If *yes*, please provide the Social Insurance Number above for the member as it is required for the issuance of the applicable tax information slip(s).
3. Did the member have any scheduled vacation days after the last day worked? ☐ No ☐ Yes
   If *yes*, how many days? _____
4. Does the member have unused sick leave? ☐ No ☐ Yes If *yes*, how many days? _____
5. Up to what date was (or will) the member's salary be paid? Date (dd-mm-yyyy) _____
6. Does the member currently receive remuneration from you? ☐ No ☐ Yes If *yes*, answer a) and b) below.
   a) How much? $ _____ per month Does this amount include unused sick leave? ☐ No ☐ Yes
   b) Until what date will remuneration continue (including sick leave credits)? Date (dd-mm-yyyy) _____
7. According to your records, what is the STD benefit amount? $ _____ per week
8. According to your records, what is the LTD benefit amount? $ _____ per month

5 Earnings and benefit information (continued)

9. To your knowledge, has the member applied for any disability/retirement benefits from CPP, QPP or any other government sponsored plan? ☐ No ☐ Yes

   If *yes*, select benefit type: ☐ Disability ☐ Retirement

10. Does the member belong to a retirement or superannuation plan?

    ☐ No ☐ Yes If *yes*, Registration number

11. Is the member eligible for retirement pension? ☐ No ☐ Yes If *yes*, give details below.

☐ **reduced pension** On what date? Date (dd-mm-yyyy) Amount $

Has the member applied? ☐ No ☐ Yes

☐ **unreduced pension** On what date? Date (dd-mm-yyyy) Amount $

Has the member applied? ☐ No ☐ Yes

☐ **medical pension** On what date? Date (dd-mm-yyyy) Amount $

Has the member applied? ☐ No ☐ Yes

6 Workers' Compensation

If the member's illness or injury is work related, have they applied for Workers' Compensation benefits?

☒ No ☐ Yes If *yes*, please continue.

What is the claim number? How much is the benefit per month? $

What is the effective / first payment date? Date (dd-mm-yyyy)

7 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First name	Position
Authorized signature X		Date (dd-mm-yyyy)
Telephone number	Fax number	

If you have access to our Group Benefits Absence & Disability web portal, you can submit completed forms electronically through the portal. Alternatively, please fax this form, along with any other information in support of the plan member's claim, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

If you live in the Atlantic provinces, Quebec or Ottawa

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

For all other provinces or territories

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

Disability Job Demands Questionnaire
SunAdvantage

Sun Life Financial

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This form is to be completed by the Plan Sponsor and submitted with the Plan Sponsor's Statement if the plan member is expected to be absent for 4 weeks or more.

Clear

1 Plan Member information

Contract number	Sub./Class	Member ID	Division/Billing group number

Last name (Quebec residents – maiden name)	First name

☐ Male ☐ Female	Date of birth (dd-mm-yyyy)	Company name

Regular occupation title/Job name

2 Work environment and job activities

The remainder of this form asks for information on the plan member's specific job duties and should be completed by the plan member's immediate supervisor.

Attach extra sheets, if necessary.

If there is a prepared job description, please attach it to this form.

1. Does the plan member's job require work in any of the following conditions:

Outside	☐ No	☐ Yes	If yes, what percentage of time?	%
In extremes of cold or heat	☐ No	☐ Yes	If yes, what percentage of time?	%
In a damp or humid environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a noisy environment	☐ No	☐ Yes	If yes, what percentage of time?	%
In a dusty or unventilated environment	☐ No	☐ Yes	If yes, what percentage of time?	%
Around toxic fumes	☐ No	☐ Yes	If yes, what percentage of time?	%

2. Does the plan member's job involve handling chemicals? ☐ No ☐ Yes If yes, please list the chemicals below.

3. During the plan member's normal routine, what percentage of time does the job require the member to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
More than 50 lbs/22.7 kg	☐	☐	☐	☐	☐
More than 20 lbs/9.1 kg	☐	☐	☐	☐	☐
More than 10 lbs/4.5 kg	☐	☐	☐	☐	☐

2 Work environment and job activities (continued)

4. During the plan member's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐
Daytime	☐	☐	☐	☐	☐
Nighttime	☐	☐	☐	☐	☐
Reaching:	☐	☐	☐	☐	☐
Above shoulder height	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder height	☐	☐	☐	☐	☐
Bending or crouching	☐	☐	☐	☐	☐
Kneeling or crawling	☐	☐	☐	☐	☐

5. How much time is the plan member required to maintain the following activities before changing position or activity?

	0 to 30 minutes	30 to 60 minutes	60 to 90 minutes	More than 90 minutes
Sitting at one time	☐	☐	☐	☐
Standing at one time	☐	☐	☐	☐
Driving at one time	☐	☐	☐	☐

6. During the average day, what is the number of hours the plan member spends in the following positions or activities?

	0 to 2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Driving	☐	☐	☐	☐

7. Please list any machines, tools, or other equipment that the plan member uses on the job. You can either list the number of times per day the equipment is used or the percentage of time spent using the equipment, whichever is more applicable.

Type of equipment	Number of times per day OR Percentage of time

8. Cognitive/non-physical aspects of the job

Does the plan member have to answer complaints? ☐ Yes ☐ No

Is the plan member primarily evaluated on production? ☐ Yes ☐ No

Does the plan member work closely with co-workers? ☐ Yes ☐ No

Is the plan member responsible for the performance objectives/decision–making within his/her particular department? ☐ Yes ☐ No

Number of people this plan member supervises: ☐

What percentage of the plan member's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

2 Work environment and job activities (continued)

Please list any other relevant aspects of the job that may be considered stressful.

3 Additional remarks

Please provide any additional information that may be relevant to this claim which has not been previously provided.

4 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First name
Position of person signing this statement (please print)	
Authorized signature X	Date (dd-mm-yyyy)
Telephone number	Fax number

To ensure prompt submission, please fax this form, along with any other information in support of the plan member's claim, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

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