Sun Life Assurance Company of Canada
Life benefits claims packet

Use this claims packet for the following:

- waiver of premium benefits—totally disabled without further premium payments
- accelerated benefits—terminal illnesses
- accidental dismemberment benefits—accidental bodily injury or loss
- permanent total disability benefits—permanently and totally disabled

Do not use this claims packet for death claims. Instead, use the Sun Life Assurance Company of Canada death claims packet (XGR/2361).

Instructions for the plan administrator

In the event of illness, dismemberment, or disability of an insured, please follow these steps as soon as you determine whether the insured is eligible for accelerated benefits, waiver of premium benefits, permanent total disability benefits, and/or accidental dismemberment benefits.

1. Complete the employer's section of this claims packet and collect the following:
   - ☐ a copy of any and all enrollment forms
   - ☐ a copy of the most recent beneficiary designation on file
   - ☐ a copy of payroll records for at least the last 6 months prior to the date of disability

2. The claimant completes the claimant's statement and authorizations and collects the following:
   - ☐ a copy of all medical records from date of disability/loss to present

3. The physician completes the attending physician statement section

4. **The employee collects all completed sections and additional required information and submits the entire packet to:**

   Sun Life Assurance Company of Canada
   Group Life Claims
   P.O. Box 81365
   Wellesley Hills, MA 02481
   Tel: 800-247-6875
   Fax: 888-551-2084

Failure to provide complete and accurate information could result in the need for an additional claims investigation, which could delay the initial benefit payment or the approval of the waiver of premium.

Fraud warnings

State law requires that we notify you of the following:

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud warning—AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Fraud warning—AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Fraud warning—AR, LA, MA, MN, NM, RI, TX, and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud warning—CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud warning—CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud warning—District of Columbia: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud warning—IN, ID, and DE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—KS: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

Fraud warning—KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Fraud Warnings continued

Fraud warning—MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits

Fraud warning—NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Fraud warning—NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud warning—OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud**.**

Fraud warning—OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—OR: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud warning—PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Fraud warning—VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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Sun Life Assurance Company of Canada
Life benefits claims packet

Section A: Employer's statement

1 General information

Type of claim: ☐ Waiver of premium benefits ☐ Accidental dismemberment benefits ☐ Accelerated benefits ☐ Permanent total disability benefits

Please print clearly.

Employer's name	Group policy number	Class
Employer contact (name of person completing this form)	Title	
Employer's street address	City	State / Zip code
Employer's email address	Telephone number	Fax number
Name and address of division where employee works		

2 Employee information

Employee's name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Employee's home address	City	State / Zip code

3 Dependent information

Complete only if submitting a dependent claim.

Dependent's name (first, middle initial, last) ☐ M ☐ F	Date of birth (m/d/y)	Relationship to employee

4 Employment and claims information

Basic insurance amount $	Optional insurance amount $	Number of regular hours worked
Date of disability or loss (m/d/y)	Date hired (m/d/y)	Effective date of insurance
Why did employee cease working? ☐ Illness ☐ Leave of absence ☐ Layoff ☐ Retired	☐ Still working ☐ Date last worked: _____	Occupation

5 Salary and benefits information

How was the employee paid? (check one)

☐ Hourly $ per hour:	☐ Salaried $ per year:

Provide information about other income:

Commissions $	Bonuses $	Overtime $

What was the date of the last pay increase?

Please attach the following and submit with the completed employer's statement:

- all enrollment and beneficiary forms
- documentation of the employee's current class and benefit
- payroll records for at least the last 6 months prior to the date of disability

6 Certification and signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warnings in this packet.

Signature of plan administrator X	Date signed

Sun Life Assurance Company of Canada
Life benefits claims packet

Section B: Claimant's statement

It is the responsibility of the claimant to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

1 General information

Please print clearly.

Employee's name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Employee's home address	City	State / Zip code
☐ Single ☐ Widowed ☐ Married ☐ Divorced	Occupation	Telephone number
Employer's name		Group policy number

2 Information about the disability/loss

***You may elect to receive up to 75% of your group life insurance benefit once during your lifetime, subject to your plan maximum. Benefits may vary by state and by contract.**

What was the date of your accident or when did you first notice symptoms of your illness (m/d/y)?

Describe how, when, and where the accident occurred or the nature of your illness and its first symptoms.

For accidental dismemberment only—please state the date and nature of your loss.

For accelerated benefits only—write in the amount you are requesting.*

Date you were first treated by a physician	Date last worked prior to disability
Have you returned to work? ☐ Yes ☐ No If yes, give date	Did you work a full day? ☐ Yes ☐ No

3 Information about physicians and hospitals

Please provide the names and addresses of all physicians you have seen for this condition.

If you need more space, attach additional pages.

Physician's name	Physician's phone number
Address	
Specialty	Date of treatment

Physician's name	Physician's phone number
Address	
Specialty	Date of treatment

3 Information about physicians and hospitals, continued

Please provide this information if you have been hospital-confined for this condition.

If you need more space, attach additional pages.

Name of hospital	Date of confinement
Address	

Name of hospital	Date of confinement
Address	

4 Information about your training, education, and experience

Complete this section if this is a waiver of premium claim.

Please attach a copy of your resume, if applicable.

What is your level of education?

☐ Grade school ☐ High school ☐ Trade school ☐ College

☐ Other course (please specify) _____

List all previous occupations and the dates worked for each employer.

Employer's name	Dates of employment	Occupation/type of work

5 Information about Social Security disability benefits

Have you applied for Social Security? ..... ☐ Yes ☐ No

If "yes," what is the status of your application?

☐ Pending ☐ Approved ☐ Denied ☐ Other: _____

6 Signature

Reminder: Please be sure to sign and return any authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this claims packet.

Employee's signature	Date signed
X	

Section C: Authorization

Authorization for release and disclosure of health-related information

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:
Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records relating to my physical or mental condition, such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand that: (a) this authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims, Sun Life Financial, P.O. Box 81365, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Authorization for release and disclosure of psychotherapy notes

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:
Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and re-insurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

I understand that (a) this authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims, Sun Life Financial, P.O. Box 81365, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Authorization for release and disclosure of non-health-related information

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:
Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf; (b) benefits plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; or (i) government agency, or (j) the Medical Information Bureau, Inc. or Pharmacy Information Bureau, Social Security Administration, Internal Revenue Service, or the Veteran's Administration to disclose to Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and reinsurers, any and all non-health information relating to me, including but not limited to (a) my employment earnings; (b) my occupational duties; (c) my credit history; (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I or my dependents may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that the Company will use the information it obtains to (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance, and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

If this authorization is signed in connection with a claim for insurance benefits, I hereby authorize the Company to disclose any information it obtains about me to any (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist, or therapist/counselor of mine for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim. I further authorize the Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law. This authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Life Claims, Sun Life Financial, P.O. Box 81365, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

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Section D: Attending physician's statement—physical conditions only

It is the responsibility of the claimant to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

1 Information about the patient

The patient is responsible for any costs associated with the completion of this form.

Please print clearly.

Name of patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)	
Patient's home address	City	State	Zip code
Name of employer	Group policy number	Employee phone no.	

Do you believe this patient is competent to endorse checks? ..... ☐ Yes ... ☐ No

2 Diagnosis and history

Provide general information about diagnosis, treatment, doctor's notes, and history in this section.

Diagnosis, including any complications and ICD-9 codes(s)		
For accelerated benefits only—if the patient has a terminal illness, please indicate the life expectancy: _____ Months ☐ N/A		
Include objective findings (i.e., X-rays, EKGs, MRIs, laboratory data, and any other clinical findings) ☐ N/A		
Subjective findings ☐ N/A		
Date symptoms first appeared or accident occurred (m/d/y) ☐ N/A	Date disability commenced (m/d/y) ☐ N/A	
If injury due to a motor vehicle accident, indicate the state in which the accident occurred		
Patient's height:	Patient's weight:	Blood pressure:
Is condition due to injury/sickness arising out of patient's employment? ☐ Yes ☐ No		
Names and addresses of other treating physicians (if applicable)		
If pregnancy, please provide the following information: Expected delivery date: Actual delivery date: C-section?: ☐ Yes ☐ No		
Describe any complications that would extend this disability longer than a normal pregnancy.		

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention, and medications prescribed.

Date of first visit ☐ N/A	Date of last visit ☐ N/A	Date of last examination ☐ N/A
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☐ Other (please specify: _____)		
Description of treatment		

4 Progress

Patient's progress: ..... ☐ Unchanged ☐ Retrogressed ☐ Improved ☐ Recovered

Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain		
If patient has been hospital confined, give dates	From:	To:
Provide name and address of hospital (if applicable)		

5 Limitations

Please note that additional occupational information may be required.

Patient may use hands for repetitive actions such as:

	Simple grasping		Firm grasping		Fine manipulating	
Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Patient may use feet for repetitive movement, as in operating foot controls ..... ☐ Yes ☐ No

During the day, is the patient able to:

	67%–100%	34%–66%	1%–33%	0%
Drive	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist body	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Grasp	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Lift _____ lbs.	☐	☐	☐	☐
Carry _____ lbs.	☐	☐	☐	☐

Is the patient capable of working within these restrictions/limitations? ..... ☐ Yes ☐ No

Can the employee work an 8-hour day with the above restrictions? ..... ☐ Yes ☐ No

If not, how many hours could he or she work with the above restrictions? _____

6 Physical impairment

- ☐ No limitation of functional capacity; capable of heavy work*..... No restrictions (0%–10%)
- ☐ Medium manual activity* .....(15%–30%)
- ☐ Slight limitation of functional capacity; capable of light work*.....(35%–55%)
- ☐ Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary*) activity.....(60%–70%)
- ☐ Severe limitation of functional capacity; incapable of minimum (sedentary*) activity..... (75%–100%)

* As defined in the *Federal Dictionary of Occupational Titles.*

7 Cardiac (if applicable)

Functional capacity (American Heart Association)

☐ No limitation ☐ Slight limitation ☐ Marked limitation ☐ Complete limitation

Therapeutic class (activity)

☐ No restriction ☐ Slight restriction ☐ Marked restriction ☐ Complete restriction

Blood pressure—last visit _____

8 Work capabilities

Is patient capable of working within these limitations? ..... ☐ Full time ☐ Part time
Is patient capable of another occupation on a full-time basis? .....☐ Yes ☐ No
Is patient capable of another occupation on a part-time basis?.....☐ Yes ☐ No

9 Prognosis

How long will those limitations apply? (estimate)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

10 Certification and signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Name of attending physician		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Telephone number	Fax number	
Signature of attending physician X		Date	

Section E: Attending physician's statement—behavioral health conditions only

It is the responsibility of the claimant to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

1 Patient information

Please print clearly.

The patient is responsible for any costs associated with the completion of this form.

Name of patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)

Do you believe this patient is competent to endorse checks? ..... ☐ Yes ☐ No

- ☐ Patient is able to function under stress and engage in interpersonal relations (no limitation)
- ☐ Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
- ☐ Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
- ☐ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
- ☐ Patient has significant loss of psychological, physiological, personal, and social adjustments (severe limitation)

In order to evaluate a claim for disability benefits submitted by your patient, we need more detailed information about his or her medical condition. Please respond to the following questions.

Axis I		DSM IV TR code	
Axis II		DSM IV TR code	
Axis III		No code	
Axis IV		No code	
Axis V			

GAF: Current:	Baseline:	Highest in past year:

2 Treatment information

When did the patient first experience psychiatric symptoms?
What was the first date you treated the patient for symptoms?
Name of first treating physician for symptoms (first, middle initial, last)
Please list facilities and dates of any hospitalization, intensive outpatient program, or partial hospitalization program.
What was the diagnosis at that time?

2 Treatment information, continued

Current diagnosis
Describe the patient's current psychiatric symptoms and mental status evaluation.
Is the patient's current condition related to chemical dependency?..... ☐ Yes ☐ No If yes, please describe

Has there been any psychological testing? If available, provide results. If not, why? Are there any plans in the future to perform testing?
Describe the current treatment methods/treatment plan.
List medications with dosages. Please note any recent changes.
Please describe patient's response to treatment to date. (Include any past treatments and additional methods of treatment being considered.)
Please describe if the patient's psychiatric condition is limiting the patient's functional capacity.

3 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

4 Certification and signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Name of attending physician		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Telephone number	Fax number	
Signature of attending physician X		Date	

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
800-247-6875

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances, and activities.

We also may collect information about you from other sources. By signing the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-related facilities
- other insurance companies you have applied to for insurance
- public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to disclose information we have about you:

- to our reinsurers and
- as required or permitted by law.

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- companies that help us conduct our business or perform services on our behalf,
- your physician or treating medical professional, and
- comply with federal, state or local laws, respond to a subpoena or comply with an injury by a government agency or regulator.

ACCESS, CORRECTION, AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information),
- request that we correct, amend, or delete any recorded personal information about you in our possession, and
- file your own statement of facts if you believe that the recorded personal information we have about you is incorrect.

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Assurance Company of Canada
Group Life Claims,
P.O. Box 81365
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