

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



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 56000	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	
	Yes	No		Yes	No	Current	Expected	<input type="checkbox"/> Week	<input type="checkbox"/> Month
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 to:

Christian Labour Association of Canada
Attention: Plan Administrator, Benefit Division
 14920 118 Ave.
 Edmonton AB T5V 1B8
 Fax: 1 866 639-7820

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

Short-Term Disability Questionnaire

Physical Job Demands



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

Please submit this form with the Plan Sponsor Statement if the member is expected to be absent for 4 weeks or more.

Contract Number 56000	Member ID
Name - first and last name (Quebec residents - maiden name)	
Occupation Title/Job Name	Company Name

2 Work Environment

In addition, attach the current job description.

Does the member's job require work under any of the following conditions?

Outside	If yes, what percentage of time?	Shift work	If yes, describe
<input type="checkbox"/> No <input type="checkbox"/> Yes	%	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Please describe the work environment (e.g. damp, humid, noisy, dusty, unventilated)			

Job Activities

During the 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• driving:					
- daytime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- night-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• reaching:					
- above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• bending or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• lifting or carrying					
	None	0-10lb.	11-20lb.	21-50lb.	over 50lb.
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	1 - 30 min.	30 - 60 min.	60 - 90 min.	3 - 6 hours	6 - 8 hours
• sitting at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• standing at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• driving at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Stress/Non-Physical Aspects of the Job

	Yes	No
Does the member have to answer customer complaints?	<input type="checkbox"/>	<input type="checkbox"/>
Is the member primarily evaluated on production?	<input type="checkbox"/>	<input type="checkbox"/>
Is the member routinely subject to close supervision?	<input type="checkbox"/>	<input type="checkbox"/>
Does the member work closely with co-workers?	<input type="checkbox"/>	<input type="checkbox"/>
Is the member responsible for the performance objectives of his/her particular department?	<input type="checkbox"/>	<input type="checkbox"/>

Number of people this member supervises:

Name of any other relevant aspects of the job that are stressors:

Additional comments

Authorized signature X	Title	Date (d/m/y)
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Please fax or mail to:

Christian Labour Association of Canada
 Attention: Plan Administrator, Benefit Division
 14920 118 Ave.
 Edmonton AB T5V 1B8
 Fax: 1 866 639-7820

490S-J-56000-E-04-06 (G3181-E)

Attending Physician's Statement Short-Term Disability: General



Member Authorization

This section must be completed and signed by the member to authorize release of medical information.

Contract Number 56000	Member ID	Name - first and last name (Quebec residents - maiden name)	Date of birth (d/m/y)
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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)
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1 General Information

This form must be completed by a doctor of medicine.

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

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.

Is patient's condition due to injury or sickness caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Last day at work (d/m/y)	Date of initial visit (d/m/y)	Expected duration of disability
Date of hospital in-patient admission (d/m/y)	Date of discharge (d/m/y)	Date and nature of surgery (d/m/y)	Type of anaesthetic
Patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of referring physician	Have you referred patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of physician(s)/other
Date of first and all subsequent visits during present period of absence from work (d/m/y)	Date first unable to work because of disability (d/m/y)	Is patient competent to endorse cheques? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Diagnosis

Primary	Secondary
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History

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression
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Treatment Plan

Please list medication, dosage and frequency.
Please identify any other treatment prescribed, including nature and frequency (ie therapy).

Remarks

Please note any psychological or social difficulties which may delay recovery

Prognosis

Please note any restrictions, any complications, and/or limitations, and state prognosis
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If Cardio-related

Canadian Cardiovascular Class	OR	American Heart Association Class	If class 3 or 4, please enclose a copy of the report of the graded exercise test	Physical findings BP	Weight
Rhythm description			Angina (frequency, severity, patterns)		
Complications (e.g. cerebral vascular, peripheral vascular or diabetic conditions)					

Return to work

Expected return to work date (d/m/y)	Describe any limitations or restrictions in work duties:
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Investigations

Name of attending physician (please print)	Specialty	Telephone	Fax
Address			
Physician's signature			Date (d/m/y)

Please enclose copies of all relevant reports which objectively support the claimed disability described above (e.g. x-rays, myelograms, C.T. scans, bone scans, etc.)

Please fax or mail to Sun Life Assurance Company of Canada Group Disability Management office below:

Christian Labour Association of Canada
Attention: Plan Administrator, Benefit Division
14920 118 Ave.
Edmonton AB T5V 1B8
Fax: 1 866 639-7820

Disability Claim FAQs

What is my policy number?

For short term disability (STD) and long term disability (LTD), your policy number is 56000.

What is my member ID?

Your social insurance number is your member ID number.

When should my claim be submitted?

We encourage you to submit your claim forms as soon as possible but no later than:

- For STD claims: within 30 days of the date you became disabled.
- For LTD claims: within 90 days after the end of the elimination period (17 weeks from the date you became disabled, i.e. 17 weeks plus 90 days).

How long will it take for Sun Life to make a decision on my claim?

- For STD claims: once we receive *all three forms* (Plan Member, Plan Sponsor, and Attending Physician statements), we will make a decision within 5 business days.
- For LTD claims: once we receive the Plan Member transition statement along with any previously requested medical information, we will make a decision within 10 business days.

If my claim is approved, when do I get paid?

- For STD claims: your benefit payments begin once the elimination period has been satisfied. You are paid on a weekly basis.
- For LTD claims: your benefit payments are paid on a monthly basis, at the end of each month.

For both benefits, you may receive a cheque or have your benefits deposited directly into your bank account. If you would like direct deposit, please attach a void cheque to your application for benefits.

What is my elimination period (the period which must be completed before benefits become payable)?

If you become totally disabled because of an *accident*, you are eligible for payment on the date you become totally disabled or the first day you consult a doctor.

If you become totally disabled because of an *illness*, you are eligible for payments after 14 days of uninterrupted total disability. In either case, you are eligible for payments on the date you are hospitalized.

What are my responsibilities?

Sun Life and your employer expect that you will make reasonable efforts to:

- Recover from your illness, participate in appropriate treatment and/or rehabilitation programs.
- Inform Sun Life of any significant changes in your medical condition.
- Actively work towards returning to work, either to your own occupation or to assist in identifying other employment you may be capable of doing.
- Accept reasonable offers of modified employment from your employer.
- Inform Sun Life if you return to your job or to any other job.

Is my disability income taxed?

No, you will not receive a T4 for your disability income.

What if I am receiving income from another source?

Your disability benefits may be reduced by payments such as Canada Pension Plan/Quebec Pension Plan, Workers' Compensation, work for remuneration, or pension plan payments. Advise Sun Life if you are receiving other income from these sources.