Sun Life Assurance Company of Canada

Customized Disability Claim – Attending Physician Statement

Plan administrator instructions

The Attending Physician must:

☐ Complete, sign and date the Attending Physician Statement

☐ Submit the Attending Physician Statement directly to Sun Life Financial

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

1 Patient information

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

Name of employee (first, middle initial, last)		☐ Male ☐ Female	Group policy number
Social Security number	Date of birth (mm/dd/yyyy)	Phone number	

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

Physical conditions only

Skip this section if claim is for behavioral condition.

2 Diagnosis and history information

Provide general information about diagnosis and history in this section. Then, please elaborate in sections 3 to 7, as appropriate.

If this claim is related to a normal pregnancy, please complete this pregnancy section only.

☐ Pregnancy

Date of first visit (mm/dd/yyyy)	When did symptoms first appear? (mm/dd/yyyy)	Date first treated (mm/dd/yyyy)
Expected delivery date (mm/dd/yyyy)	Actual delivery date (mm/dd/yyyy)	Delivery type ☐ Vaginal ☐ C-section
Date first unable to work (mm/dd/yyyy)	Dates hospitalized (mm/dd/yyyy) From: To:	
Describe all complications that requires early bed rest		Date bed rest commenced (mm/dd/yyyy)
Has patient been released to work in her **own** occupation.....		☐ Yes ☐ No
Has patient been released to work in **any** occupation.....		☐ Yes ☐ No
If "No," when should the patient be able to return to work?		☐ Full-time ☐ Part-time
Describe any complications that would extend this disability longer than a normal pregnancy.		

☐ Spotting*	☐ Placenta previa*
☐ Bleeding	☐ Incompetent cervix/cerclage
☐ Contractions requiring medications	☐ Hypertension
☐ Severe pre-eclampsia	☐ Twins
☐ Other	☐ Triplets

* Please submit ultrasounds and prenatal records with the Attending Physician Statement

List all medications prescribed	Blood pressure when disability commenced Rise above systolic: Rise above diastolic:

2 **Diagnosis and history information**, continued

☐ All other physical conditions

Diagnosis including any complications		
Objective findings/investigative testing (for example, X-rays, EKGs, MRIs, laboratory data, etc.)		
Subjective findings		
Date symptoms first appeared or date of accident (mm/dd/yyyy)	If injury due to a motor vehicle accident, indicate in which state the accident occurred.	
Date first unable to work (mm/dd/yyyy)	Dates hospitalized (mm/dd/yyyy) From: To:	
Patient's height:	Patient's weight:	Blood pressure:
Is condition due to injury/sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown		
Has patient been released to work in their **own** occupation ..... ☐ Yes ☐ No		
Has patient been released to work in **any** occupation ..... ☐ Yes ☐ No If "No," when should the patient be able to return to work? ..... ☐ Full-time ☐ Part-time		
Names and addresses of other treating physicians (if applicable)		

3 **Treatment information**

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

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

4 **Progress**

Patient: ☐ Unchanged ☐ Improved ☐ Retrogressed ☐ Ambulatory ☐ Bed confined

If retrogressed, please explain:		
Has patient been hospital confined? ..... ☐ Yes ☐ No	From:	To:
If "yes," provide name of hospital		

5 Restrictions and limitations

Please note that additional occupational information may be required.

Patient is able to use hand for repetitive actions such as:

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

If the patient has demonstrated a loss of function, please describe restrictions and limitations below.

Restrictions (what the patient should not do)

Limitations (what the patient cannot do)

Date restrictions and limitations began

Physical impairment

- ☐ No limitation of functional capacity - (no restrictions)
- ☐ Medium capacity - (lifting, carrying, pushing, pulling 20-50 lbs. occasionally; 10-25 lbs. frequently; or up to 10 lbs. constantly)
- ☐ Light capacity - (lifting, carrying, pushing, pulling 20 lbs. occasionally; 10 lbs. frequently; or negligible amount constantly. Can include walking and/or standing frequently even if the weight is negligible. Can include pushing or pulling of arm or leg controls.)
- ☐ Sedentary capacity **-** (lifting, carrying, pushing, pulling 10 lbs. occasionally. Mostly sitting, may involve standing or walking for brief periods of time.)
- ☐ Comments (please explain):

Cardiac (if applicable) – Functional capacity (American Heart Association)

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

6 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

7 Remarks

Complete this section for all claimants. It's required to submit a copy of the employee's formal job description.

Please use this space for any additional comments.

8 Certification and signature

Remember to 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 or had read to me the fraud warning for my state.

Name of Attending Physician (first, middle initial, last)		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Phone number	Fax number	
Attending Physician signature X			Date

Contact us

By mail
Sun Life Assurance Company of Canada
P.O. Box 81915
Wellesley Hills, MA 02481

By fax
781-304-5537

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET

Behavioral health conditions only

2 Additional patient information

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

Mental Impairment (if applicable)	**Current DSM diagnosis**
☐ Class 1 – No limitation ☐ Class 2 – Slight limitation ☐ Class 3 – Moderate limitation ☐ Class 4 – Marked limitation ☐ Class 5 – Severe limitation	

Do you believe this patient is competent to endorse/direct the use of proceeds? ..... ☐ Yes ☐ No

3 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?

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? ..... ☐ Yes ☐ No
If "Yes," and available, provide results.

If not available, why?

Are there any plans in the future to perform testing? ..... ☐ Yes ☐ No

Please describe the 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.

4 Prognosis

How long will those limitations apply? (estimated)			
☐ 6 weeks	☐ 8 weeks	☐ 12 weeks	☐ Longer

5 Certification and signature

Remember to 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 shown below that is applicable to my state.

Name of Attending Physician (first, middle initial, last)		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Phone number	Fax number	
Attending Physician signature X			Date (mm/dd/yyyy)

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Fraud warnings

General 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.

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.

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.

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.

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.

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.

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.

DC: 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.

DE, ID and IN: 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.

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.

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.

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 is a crime.

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.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

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

Fraud warnings

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.

OK: WARNING: 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.

OR and VA: 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.

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 by 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 be 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.

TN and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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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