Disability Claim
Filing Instructions

Have you…

1. Completed the Employee's Statement in full?
2. Had the physician treating you complete the Attending Physician's Statement, and had it returned to you?
3. Had your Employer complete the Employer's Statement, and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information?

Submit the completed forms by…

- Email - myclaimdocuments@sunlife.com (Subject Line must include Policy # 930912)
- Fax - (781) 304-5537
- Mail - Sun Life Assurance Company of Canada
  PO Box 81915
  Wellesley Hills, MA 02481

All portions of these forms must be completed in order to process your claim.

If you have any questions when completing this form, please call:
1-(800) 247-6875

SUN LIFE DISABILITY CLAIM FORM QUESTIONNAIRE

PLEASE COMPLETE THIS PAGE AND RETURN IT TO PAYROLL

NAME:_____

EMPLOYEE #_____

PHONE #_____

E-MAIL_____

JOB TITLE (please provide position, campus, and subject taught)

_____

_____

LAST PHYSICAL WORK DAY PRIOR TO LEAVE_____

REQUIRED # OF HOURS SCHEDULED PER WEEK_____

WORKER'S COMP (YES OR NO)_____IF YES, DATE_____

RETURNED TO WORK (YES OR NO)_____IF YES, DATE_____

IF YOU HAVE RETURNED TO WORK, PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

SAME POSITION_____

SAME WORK HOURS_____

SAME RATE OF PAY_____

ANY WORK RESTRICTIONS_____

PLEASE INDICATE HOW YOU WOULD LIKE EMPLOYER'S STATEMENT RETURNED TO YOU

_____PICK UP _____E-MAIL _____CAMPUS MAIL _____U.S.MAIL

QUESTIONS ABOUT THIS FORM SHOULD BE DIRECTED TO PAYROLL AT (281)897-4010

Sun Life Assurance Company of Canada

Notice of Claim for Disability Benefits

Employee Statement

Name of employer	Policy number
Cypress Fairbanks ISD	930912

1 Employee information

To avoid delay, all questions must be answered.

Name of employee (first, middle initial, last)	☐ M ☐ F	Social Security number	Date of birth (mm/dd/yyyy)	
Street Address	City		State	Zip code
Occupation	Title			
Phone number	Number of dependent children	Is spouse employed ☐ Yes ☐ No	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Spouse's name (first, middle initial, last)	Date of birth (mm/dd/yyyy)
Dependent's name (first, middle initial, last)	Date of birth (mm/dd/yyyy)
Dependent's name (first, middle initial, last)	Date of birth (mm/dd/yyyy)
Dependent's name (first, middle initial, last)	Date of birth (mm/dd/yyyy)

Date of injury or date first noticed symptoms of sickness	You have been unable to work because of disability since	Last day worked
You returned to work on a part-time basis on	You returned to work on a full-time basis on	

Is your injury or sickness related to your occupation? ..... ☐ Yes ☐ No

If "Yes," please explain

Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms.
If more space is needed, please attach sheet of paper.

1 **Employee information**, continued

If "hospital confined," give name and address of hospital.

Hospital name			
Street Address	City	State	Zip code
Date first treated	Date confined From: through		

Treated by:

Hospital name			
Street Address	City	State	Zip code

Doctor name			
Street Address	City	State	Zip code

Have you ever had the same or similar condition in the past? ..... ☐ Yes ☐ No
If "Yes," when?

2 **Pregnancy information** (if applicable)

Are there any present complications or anticipated difficulties in connection with the following?

☐ Pregnancy..... ☐ Yes ☐ No Date of last menstrual period: Expected delivery date:

☐ Delivery..... ☐ Yes ☐ No Actual date of delivery: ☐ Vaginal ☐ C-Section

☐ Post-Partum..... ☐ Yes ☐ No

If "Yes," to any of these, please specify in detail:

3 **Other income information**

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

	Source of Income	**Weekly or monthly**	**Payment amount**	**Date began**	**Date term**
☐	Sick Pay	☐ Weekly ☐ Monthly	$		
☐	Salary Continuance	☐ Weekly ☐ Monthly	$		
☐	Workers' Compensation	☐ Weekly ☐ Monthly	$		
☐	Local, State or National Association or Society Disability Income Plan	☐ Weekly ☐ Monthly	$		
☐	No Fault	☐ Weekly ☐ Monthly	$		
☐	Unemployment Compensation disability	☐ Weekly ☐ Monthly	$		
☐	Social Security Disability (disability or retirement)	☐ Weekly ☐ Monthly	$		
☐	Retirement income (normal, early, or disability)	☐ Weekly ☐ Monthly	$		
☐	Other STD LTD benefits:	☐ Weekly ☐ Monthly	$		
☐	Other:	☐ Weekly ☐ Monthly	$		

4 Fraud warnings

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.

5 Certification and signature

I certify that to the best of my knowledge the above statements are true and correct. I have read or had read to me the fraud warning for my state.

Signature of employee X	Date signed (mm/dd/yyyy)

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.

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services tome or on my behalf to, or has medical or health related records or knowledge of me, 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, employees, agents, representatives, 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, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical record without restriction.

I understand that the Company may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates, (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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 of signature; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 96 Worcester Street, 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 930912
If representative, description of your authority or relationship to employee	Claimant date of birth (mm/dd/yyyy)
Signature of employee or personal representative X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Notice of Claim for Disability Benefits

Attending Physician Statement

This statement must be filled in completely by a physician.

1 Employee information

Name of patient (first, middle initial, last) ☐ M ☐ F	Date of birth (mm/dd/yyyy)
Height Weight	Blood pressure (last visit) Systolic Diastolic
	Left-handed ☐ Right-handed ☐

2 History

Is condition due to ☐ Accident ☐ Sickness

Date symptoms first appeared, or injury occurred? (mm/dd/yyyy)	Date patient was unable to work because of impairment (mm/dd/yyyy)

Has patient ever had same or similar condition? ..... ☐ Yes ☐ No
If "Yes," state when and describe.

Is condition due to injury or sickness arising out of patient's employment? ..... ☐ Yes ☐ No
If "Yes," please explain.

Was this patient referred to you? ..... ☐ Yes ☐ No
If "Yes," by whom and what is their specialty?

Have you referred this patient to another treating provider? ..... ☐ Yes ☐ No
If "Yes," by whom and what is their specialty.

3 Diagnosis

Diagnosis impacting function	ICD Code(s)
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency.	
Secondary diagnosis impacting function	ICD Code(s)
Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency.	

3 **Diagnosis**, continued

Subjective symptoms
Objective findings (including current X-rays, EKGs, Laboratory data and any clinical findings)

4 **Hospital information**

If “hospital confined,” give name and address of hospital.

Hospital name			
Street Address	City	State	Zip code
Date confined from: through			

5 **Pregnancy information** (if applicable)

Are there any present complications or anticipated difficulties in connection with the following?

☐ Pregnancy..... ☐ Yes ☐ No Date of last menstrual period: Expected delivery date:

☐ Delivery..... ☐ Yes ☐ No Actual date of delivery: ☐ Vaginal ☐ C-Section

☐ Post-Partum..... ☐ Yes ☐ No

If “Yes,” to any of these, please specify in detail:

6 **Treatment detail**

Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Date of next office visit (mm/dd/yyyy)
Frequency ☐ Weekly	☐ Monthly	☐ Other

7 **Progress**

Has patient			
☐ Recovered	☐ Improved	☐ Unchanged	☐ Retrogressed
Is patient			
☐ Ambulatory	☐ House confined	☐ Bed confined	☐ Hospital confined

8 Restrictions and limitations

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

Class 1 - No limitation Class 2 - Slight limitation Class 3 - Marked limitation Class 4 - Complete Limitation

In an 8-hour day, what is the maximum number of hours your patient could perform each of these levels of activity?

hours	Sedentary activity – 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6-8 hours
hours	Light activity – 20 lbs. maximum lifting, carrying10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling Standing 6-8 hours
hours	Medium activity – 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing
hours	Heavy activity – 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing

Please check the appropriate boxes.

	Occasionally (0% - 33%)	**Frequently** (33% - 66%)	**Continuously** (66% - 100%)
Bending	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push / pull	(lbs.)	(lbs.)	(lbs.)
Lifting	(lbs.)	(lbs.)	(lbs.)

What is this assessment based on? ☐ Observed activity ☐ Measured capacity ☐ Physical therapy report

Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (i.e., driving, working at heights, etc.) Please be specific.

Upper extremity function – please indicate upper extremity functional capabilities:

Simple grasping	☐ Left	☐ Right	Comment:
Pinch	☐ Left	☐ Right	Comment:
Fine manipulation	☐ Left	☐ Right	Comment:
Power grip	☐ Left	☐ Right	Comment:
Repetitive motion	☐ Left	☐ Right	Comment:

Mental health ability (if applicable)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

9 Return-to-work information

Have you discussed a return-to-work plan with your patient? ☐ Yes ☐ No	Date you released patient to return to work (mm/dd/yyyy)
Please identify your recommendations for any job modifications that would enable the patient to work.	

10 Certification and signature

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.

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)			Tax ID #
Street address	City	State	Zip code
Specialty	Phone Number		Fax Number

Attending Physician signature (original signature required) X	Date signed (mm/dd/yyyy)

Please return completed form to your patient / the employee.

Sun Life Assurance Company of Canada

Notice of Claim for Disability Benefits

Employer's or Administrator's Statement

1 Employee information

Name of employee			Employee ID number
Occupation		Social Security number	Date of birth
Is disability due to employment? ☐ Yes ☐ No	Date employed	Date insured	Date last worked

Reason for stopping work
☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence
☐ Other Leave of Absence ☐ Other reason:

Date returned to work ☐ Full-time ☐ Part-time: hours/week	If employee has not returned to work estimated return to work date	Date employment terminated	Date disability insurance terminated
Required number of hours per week hours	Gross annual salary (During the 12 months just prior to your employee's disability)	Please indicate how the employee is paid ☐ 9 months ☐ 10 months ☐ 12 months ☐ Other:	

Is employee subject to FICA tax? ..... ☐ Yes ☐ No
If "Yes," is the employee subject to: ☐ Full FICA tax ☐ Medicare Portion only

Percentage of employee / employer contribution to premium for this disability plan
Employee ☐ 100% ☐ Other % Is employee contribution: ☐ Pre-tax deduction ☐ Post-tax deduction
Employer ☐ 100% ☐ Other %

2 Other income information

	Source of Income	Weekly or monthly	Payment amount	Date began	Date term
☐	Sick Pay	☐ Weekly ☐ Monthly	$		
☐	Salary Continuance	☐ Weekly ☐ Monthly	$		
☐	Workers' Compensation	☐ Weekly ☐ Monthly	$		
☐	Local, State or National Association or Society Disability Income Plan	☐ Weekly ☐ Monthly	$		
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☐	Social Security Disability (disability or retirement)	☐ Weekly ☐ Monthly	$		
☐	Retirement income (normal, early, or disability)	☐ Weekly ☐ Monthly	$		
☐	Other STD LTD benefits:	☐ Weekly ☐ Monthly	$		
☐	Other:	☐ Weekly ☐ Monthly	$		

3 Reminder

Please attach a copy of the following documents with this form.

- Employee's Workers' Compensation claim(s) and Approval / Denial Notification
- Employee's prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability
- Employee's current job description

4 Certification and signature

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I certify that to the best of my knowledge the above statements are true and correct. I have read or had read to me the fraud warning for my state.

Policyholder name (company) Cypress Fairbanks ISD			
Street Address	City	State	Zip code
Phone number	Fax number		

Print name of official representative	
Title of official representative	
Signature of official representative X	Date signed (mm/dd/yyyy)

Please return completed form to the employee.