Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Sun Life Financial®

Instructions

☐ Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**

- Employer Statement
- Employee Statement
- Attending Physician Statement
- Authorization Statements

An STD claim should be submitted once a disability absence has actually begun and will extend beyond the required elimination period.

☐ Prefill the Group STD policy number and Employer name on the Employee and Physician Statements.

☐ Employer is required to include the following (as applicable):

- Enrollment Form
- Job Description
- Worker Compensation Report
- Return-to-Work slip
- W2
- Payroll Ledger

☐ Physician must completely fill out and sign the Physician Statement.

☐ Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim or check on a status online go to www.sunlife-usa.com.
- Click on Plan Member login
- Select "Start" under "File a Disability Claim"
- OR **Fax to: 781-304-5599**

Employer's Statement

Group STD policy number

1 General Information

Please print clearly.

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife-usa.com

Name of employer (parent company name)		Employer phone number	
Employer street address	City	State	Zip code

Name of employee (first, middle initial, last) ☐ M ☐ F		Social Security number	
Employee street address	City	State	Zip code
Employee phone number Home Work	Preferred form of contact ☐ Home phone ☐ Work phone ☐ Mail	Date of birth	

2 Employment and Claim Information

Attach Return-to-Work slip from physician.

Attach Worker's Compensation Report and Reward/Denial notice.

Is condition due to injury/sickness caused by patient's employment? ☐ Yes ☐ No ☐ Unknown			
Date hired	Start date of insurance	Date last worked before disability	Hours worked last day
Employee job title (Attach employee's formal job description)			
List employee's major job duties			
How would you classify the employee's occupation? ☐ Sedentary (1-10 lbs) ☐ Light (11-20 lbs) ☐ Medium (21-50 lbs) ☐ Heavy (51+ lbs)			
Indicate days per week the employee regularly works? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7			
Indicate daily hours the employee regularly works. ☐ 8 ☐ 9 ☐ 10 ☐ Other:			
Has employee terminated employment? ☐ Yes ☐ No If yes, termination date:			
Has employee returned to work? ☐ Yes ☐ No If yes, return date: If yes, did employee return: ☐ Full-Time (full-capacity) ☐ Full-Time (partial capacity) ☐ Part-Time (attach payroll ledger)			
Has Worker's Compensation claim been filed? ☐ Yes ☐ No			
Name of Worker's Compensation carrier			Phone number

3 Salary and Benefits Information

If employee contributes to STD premium, attach a copy of employee enrollment form

How was the employee paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per week:

Other work related income:

Commissions	Bonuses	Overtime
$	$	$

How does employee contribute toward the STD premium?

☐ PRE-tax ☐ POST-tax ☐ Employee does not contribute

If employee contributes, please provide percentage..... _____ %

4 Information About Other Income

Indicate whether the employee is currently receiving, or entitled to receive, benefits from any of these sources.

Check all that apply.

	Source of income	Payment Amount	Weekly or monthly?	Payment Coverage (M/D/Y)
☐	Sick pay	$	☐ Wkly ☐ Mthly	From: To:
☐	Salary continuance	$	☐ Wkly ☐ Mthly	From: To:
☐	State Disability	$	☐ Wkly ☐ Mthly	From: To:
☐	Worker's Compensation	$	☐ Wkly ☐ Mthly	From: To:
☐	Unemployment	$	☐ Wkly ☐ Mthly	From: To:
☐	Social Security Disability	$	☐ Wkly ☐ Mthly	From: To:
☐	Other:	$	☐ Wkly ☐ Mthly	From: To:

5 Certification and Signature

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

Name of person completing this form	E-mail address
Title	Phone number
Signature (original signature required) X	Date signed

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Employee's Statement

Group STD policy number

1 General Information

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife-usa.com

Name of employee (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Employee street address	City	State / Zip code
Home phone: Cell phone: Work phone:	Preferred form of contact: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Mail	
Name of employer (parent company name)		

2 Information About the Condition Causing Your Disability

Last day worked before disability	Date first treated by Physician	Date expected to return to work ☐ FT ☐ PT
Did you require Emergency Room care for your condition? ☐ Yes ☐ No If yes, Hospital name: Date: Phone:		
Were you confined to a hospital for this condition? ☐ Yes ☐ No		
If yes, include the hospital name	Hospital phone	
Date(s) of confinement: From: To:		

Select the appropriate type of condition, and provide details:

☐ **Pregnancy**
Expected due date: Actual due date:
Delivery type: ☐ Normal ☐ C-Section
Complications:

☐ **Work-related injury/sickness**
Date of first symptom/injury:
Where occurred:
Cause of injury/sickness:
Do you intend to file for Workers Compensation? ☐ Yes ☐ No
If yes, what is the status: ☐ Denied ☐ Approved ☐ Pending ☐ Appealed

☐ **Sickness** First date of symptom:
Type of sickness:
Have you experienced a symptom in the past? ☐ Yes ☐ No Date:

2 Information About the Condition Causing Your Disability continued

☐ **Motor vehicle accident** - complete only if applicable
Date occurred: Time: ☐ AM ☐ PM
Was a citation issued to you? ☐ Yes ☐ No
If yes, type of citation:

How injury occurred:
Where injury occurred:

Name of your car insurance carrier:
Phone number:

Are you receiving compensation from a car insurance carrier? ☐ Yes ☐ No
If yes, Date: From: To:

☐ **Other injury**
Date occurred: Where occurred:
How occurred:
Describe type of injury:

3 Information About Other Income

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

☐ Sick pay/Salary continuance ☐ State Disability ☐ Worker's Compensation
☐ Other:

4 Physician Information

Indicate physicians you are seeing or have seen for this condition.

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

5 Signature

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

Employee's signature X	Date signed

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Sun Life Financial®

Attending Physician's Statement

Group STD policy number

1 Information About the Patient

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

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599

www.sunlife-usa.com

Name of patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Name of employer (parent company name)		
Patient home street address	City / State / Zip code	
Patient home phone number	Patient work phone number	

2 Physician Information

- Complete all sections – any missing information may result in a delay to your patient
- Print clearly
- Fax this form to 781-304-5599 or as instructed by patient

Name of attending physician (first, middle initial, last)	Specialty	Tax ID#
Street address	City / State / Zip code	
Phone number	Fax number	

List other physicians treating for this condition

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

3 Diagnosis and History

Your response is required and affects the patient's benefit. Failure to complete this information may cause the patient financial hardship due to lack of benefit payments.

Primary Diagnosis (include any complications)	ICD-9 Code
Secondary Diagnosis (if applicable)	ICD-9 Code
Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, date occurred:	
If pregnancy, provide the following: Expected delivery date: Actual delivery date:	Delivery type: ☐ Normal ☐ C-Section
List any complications pre or post delivery that would extend this disability longer than a normal pregnancy.	
Is condition due to injury/sickness arising out of patient's employment? ☐ Yes ☐ No ..... ☐ Unknown	

Describe objective or abnormal findings and date.

If you need more room, check here ☐

☐ X-ray ☐ EKG ☐ MRI ☐ PFT ☐ Ultrasound ☐ Other data (e.g. Labs)	
Date(s):	

and attach a separate sheet.	Findings:

4 Treatment Details

Start date of disability	Date of first office visit	Date of last office visit	Date of next office visit

Was Emergency Room care required for condition? ☐ Yes ☐ No

Name of hospital	Date	Phone number

Check all that apply and describe type, frequency and treatment

☐ Surgery ☐ Medications prescribed ☐ Therapy ☐ Behavioral intervention ☐ Other

Date(s):

Procedure/Treatment:

Is patient: ☐ Hospital confined Date from: Date to:
☐ House confined ☐ Bed confined ☐ Ambulatory
Hospital name: Phone:

5 Restrictions and Limitations

Describe what the patient **can do.**	From: To:
Describe what the patient **should not do.**	From: To:

Is patient capable of working with these restrictions/limitations? ☐ Yes ☐ No
☐ Full-Time: 8+ hours/day ☐ Part-Time: _____ hours/day

Indicate class of impairment - As defined in federal dictionary of occupation titles

Physical Impairment

☐ Class 1 – No limitation ☐ Class 4 – Moderate limitation
☐ Class 2 – Slight limitation ☐ Class 5 – Severe limitation
☐ Class 3 – Medium limitation

Mental Impairment (if applicable)	**Current DSM-IV-R diagnosis**
☐ Class 1 – No limitation	Axis I:
☐ Class 2 – Slight limitation	Axis II:
☐ Class 3 – Moderate limitation	Axis III:
☐ Class 4 – Marked limitation	Axis IV:
☐ Class 5 – Severe limitation	Axis V:

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

6 Return-to-Work

Indicate the specific date or recovery period for when the patient will recover sufficiently to perform duties.

- Return to patient's occupation full-time: Date: _____ **-or-**
  ☐ 1-2 wks ☐ 2-3 wks ☐ 3-4 wks ☐ 4-5 wks ☐ 5-6 wks ☐ 6-7 wks ☐ 7-8 wks
  ☐ 2 months or more ☐ Other: _____ ☐ Never
- Return to patient's occupation part-time: Date: _____ **-or-**
  ☐ 1-2 wks ☐ 2-3 wks ☐ 3-4 wks ☐ 4-5 wks ☐ 5-6 wks ☐ 6-7 wks ☐ 7-8 wks
  ☐ 2 months or more ☐ Other: _____ ☐ Never

7 Certification and Signature

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

Attending Physician Signature (original signature required) X	Date

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 – AR, KY, LA , MA , MN, NM, 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 - 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 - 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: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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 – MD: 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 - 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 – PA: Any person who knowingly and with intent to defraud any insurance company or any other person files a claim for insurance, 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 – 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.

Sun Life Assurance Company of Canada

Sun Life Financial®

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 Authori-zations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or healthcare 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 redisclosed 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 Sun Life Financial, Group Short Term Disability Claims, SC4312, One Sun Life Executive Park, 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

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 upon 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
- 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
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry 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
- 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 Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481