

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant



Instructions for the Claimant

Please mail all documents 4-6 weeks before the end of your elimination period.

Please make sure to initiate the Long Term Disability claim filing process as soon as it first appears that your disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

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.

Please be sure to submit the Employer's Statement directly to Sun Life Financial.

The Employee must:

- Sign and date the Employer's Statement
- Sign and date the Authorizations
- Sign and date the Reimbursement Agreement
- Have the employer complete and return the Employer's Statement to Sun Life Financial
- Have the physician complete and return the Attending Physician's Statement to Sun Life Financial
- Attach a copy of a photo ID (i.e., license or passport)
- Attach a detailed job description (from employer)

Mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

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

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant



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 - California: 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 - Colorado: 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 - Florida: 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 - Louisiana and Massachusetts: 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 - Maryland: 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 as determined by a court of competent jurisdiction.

Fraud Warning - New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning - Oregon and Virginia: 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 - Vermont: 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 may be a crime and subjects such person to criminal and civil penalties.

Fraud Warning - Washington: 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.

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant



Employee's Statement

1 General Information

Please print clearly.

Return to:
 Sun Life Assurance
 Company of Canada
 Group LTD Claims,
 SC 3208
 1 Sun Life Exec. Park
 P.O. Box 81830
 Wellesley Hills, MA 02481
 Fax: (781) 304-5537

Name of employee (first, middle initial, last) <input type="checkbox"/> M <input type="checkbox"/> F		Social Security number	Group policy number	
Street address		City	State	Zip Code
Occupation	Date of birth	Phone number	Marital status	
Spouse's name (first, middle initial, last)		Social Security number	Date of birth	

Is your spouse employed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Names and dates of birth of your children (under age 25)	

2 Information About the Condition Causing Your Disability

If a motor vehicle accident has occurred and is the cause of the disability, a motor vehicle accident report is required to be included with this statement.

Date of accident or date you first noticed symptoms of your illness _____		
Describe in detail how, when and where the accident occurred –OR– Describe the nature of your illness/condition and its first symptoms.		
Is your condition due to injury or sickness related to your job?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain below.		
Date you were first treated by a physician	Last date worked prior to disability	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date first unable to work	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: _____ <input type="checkbox"/> With restrictions <input type="checkbox"/> Full capacity	
If work-related, have you filed/do you intend to file, a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date: _____		

3 Your Treating Physician(s)

If you need more space, check here and attach a separate page.

Name of physician		Specialty	
Address			
Telephone number	Fax number	Date of last visit	Date of next visit
Have you discussed a return to work plan with this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Continued on next page

3 Your Treating Physician(s) continued

Name of physician		Specialty	
Address			
Telephone number	Fax number	Date of last visit	Date of next visit
Have you discussed a return to work plan with this physician?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

4 Hospitals

If you need more space, check here and attach a separate page.

1.	Name of hospital	Telephone number	Dates of confinement to
2.	Name of hospital	Telephone number	Dates of confinement to

5 Other Income Information

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

Check all that apply and provide award/denial notice or application associated with any source of income.

Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
<input type="checkbox"/> Sick Pay	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Salary Continuance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> State Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Workers' Compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Unemployment Compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Social Security Disability/Retirement	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Disability/Retirement Pension	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Automobile No-fault Insurance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Union Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Severance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
<input type="checkbox"/> Other:	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	

6 Education and Training Information

Please indicate your highest level of education completed. <input type="checkbox"/> Less than High School (Grade: _____) <input type="checkbox"/> High School (GED) <input type="checkbox"/> College		
Name of school / college		
Degree	Dates attended	Field of study
Additional Course Work, Education, Training, Special Skills and/or Hobbies		

7 Experience Information

Military Experience

Did you serve in the armed forces? <input type="checkbox"/> Yes <input type="checkbox"/> No		Branch of service
Highest rank	Dates of service to	Specialty

Continued on next page

7 Experience Information continued

If you have a resume, please attach a copy. You may use this section to indicate any additional experience.

Work Experience

Please list chronologically all of the jobs you have held. Start with your current or most recent job. Provide as many details as possible.

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Skills Development

What, if any, training or education would you be interested in pursuing?
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8 Checklist of Required Attachments

Please mail all documents 4-6 weeks before the end of your elimination period. **Failure to provide the following information could result in a delay of the initial benefit payment.**

- Sign and date the Employee's Statement
- Sign and date the Authorizations
- Sign and date the Reimbursement Agreement
- Employer completed and returned the Employer's Statement
- Physician completed and returned the Attending Physician's Statement
- Attach a copy of a photo ID (i.e., license or passport)

We will contact you as soon as we have received and reviewed your claim forms and medical records. In the meantime, should you have any questions, please call our Customer Service Center at 1-800-247-6875.

9 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 on page 2 of this packet.

Employee's signature X	Date signed
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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 Assurance
Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

I HEREBY AUTHORIZE any physician, healthcare 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, 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 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 Group Long Term Disability Claims, Sun Life Financial, SC 3208, 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

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 Assurance
 Company of Canada
 Group LTD Claims
 P.O. Box 81830
 Wellesley Hills, MA 02481
 Fax: (781) 304-5537

I HEREBY AUTHORIZE any: physician, healthcare provider, health plan, medical professional, hospital, clinic, or other medical or healthcare 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 reinsurers.

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 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 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 Group Long Term Disability Claims, Sun Life Financial, SC 3208, 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

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 Assurance
Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., 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 redisclosed 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 Long Term Disability Claims, Sun Life Financial, SC 3208, 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

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Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant



Reimbursement Agreement

Return to:
 Sun Life Assurance
 Company of Canada
 Group LTD Claims
 P.O. Box 81830
 Wellesley Hills, MA 02481
 Fax: (781) 304-5537

I UNDERSTAND and agree that the provisions of Group Long Term Disability Policy No. _____ permit Sun Life Assurance Company of Canada (herein called the “Company”) to offset from my monthly disability benefit any benefits received from Social Security and/or Workers’ Compensation or as otherwise provided in the Group Long Term Disability Policy. I further UNDERSTAND and agree that the Company may offset any such amounts that I or my dependents are eligible to receive, whether or not I or my dependents are actually receiving said amounts.

In return for the Company’s advance payment of the Long Term Disability benefits to which I may be entitled, which advanced amount may be in excess of the amount due to me under the terms of the policy, I, for myself, my heirs, executors, administrators and assigns agree:

1. That I am not currently receiving any benefits from Social Security and/or Workers’ Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy.
2. To apply for Social Security disability benefits and/or Workers’ Compensation benefits, and/or any Other Income benefit to which I or my dependents may be eligible as described in the policy.
3. If I, and/or my spouse and family receive any disability payments, regardless of the amount, in connection with Social Security and/or Workers’ Compensation, and/or any Other Income benefit to which I or my spouse and family may be eligible as described in the policy; I and/or my spouse and family will immediately notify the Company of such disability payments and will pay back all amounts over and above the amounts to which I would be entitled under the policy provisions.
4. I understand that thereafter the Company is entitled to offset any amounts received from Social Security and/or Workers’ Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy with the monthly benefit payable under the policy in accordance with the terms of the policy.

I UNDERSTAND that the Company, in reliance on the above statements and promises, has agreed to advance to me the disability benefits to which I or my dependents are entitled under the terms of the policy.

Print name	Group policy number
Signature of employee X	Date
Signature of witness X	Date

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, healthcare providers, medical professionals, hospitals, clinics or other medical or healthcare 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 Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481