Waiver of premium claim – Claimant's statement

Sun Life Financial

Please PRINT clearly.

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

Clear

1 General information

Information about you

Member ID number	Contract number	Provincal health insurance plan number

Title ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last name	First name	Sex ☐ Male ☐ Female

Date of birth (dd-mm-yyyy) – –	Language ☐ English ☐ French	Social insurance number if different from Cert. no./ID no. (required for tax purposes)

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone – –

Information about your plan sponsor/employer

Your plan sponsor/employer	Your occupation

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone – –

2 Medical information

Condition

Describe your present medical condition, it's cause and history (if you were injured, also describe the accident, including when and where it took place)

Date symptoms began (dd-mm-yyyy) – –	Date medical condition prevented you from working (dd-mm-yyyy) – –

Have you ever had a similar illness or injury in the past? ☐ Yes ☐ No

If *yes*, describe your condition, the original date of illness or injury, and any time lost from work

If your condition is the result of an injury, was another party at fault? ☐ Yes ☐ No

If *yes*, are you considering, or have you started, legal action? ☐ Yes ☐ No

2 Medical information (continued)

Attach copies of all available specialists' reports.

Treatment

List all physicians you have seen for your present condition

Physician's name		Address	
Date seen (dd-mm-yyyy) From — —	To — —	Date of hospitalization (dd-mm-yyyy) From — —	To — —
Physician's name		Address	
Date seen (dd-mm-yyyy) From — —	To — —	Date of hospitalization (dd-mm-yyyy) From — —	To — —
Physician's name		Address	
Date seen (dd-mm-yyyy) From — —	To — —	Date of hospitalization (dd-mm-yyyy) From — —	To — —
Physician's name		Address	
Date seen (dd-mm-yyyy) From — —	To — —	Date of hospitalization (dd-mm-yyyy) From — —	To — —

Work details

Have you, or did you, attempt to return to work? ☐ Yes ☐ No	If *yes*, **from** date (dd-mm-yyyy) — —	**to** date (dd-mm-yyyy) — —	☐ full-time ☐ part-time ☐ usual job ☐ new job/duties
If *no*, date you expect to return to your own occupation (dd-mm-yyyy) — —		Date you expect to return to any other occupation (dd-mm-yyyy) — —	
Are you currently involved in a rehab/training program? If *yes*, please provide details.			

Attach copies of all correspondence you have received, related to this matter.

Benefits

Are you claiming or receiving any other disability, wage loss, and/or retirement benefits? ☐ Yes ☐ No
If *yes*, complete this section.

☐ WCB If *yes*, complete the WCB release form on page 6.	Amount $	Frequency	Effective (dd-mm-yyyy) — —	Claim number
☐ CPP/RPP Disability Pension	Amount $	Frequency	Effective (dd-mm-yyyy) — —	Claim number
☐ Car Insurance	Amount $	Frequency	Effective (dd-mm-yyyy) — —	Claim number
☐ Group Benefits	Amount $	Frequency	Effective (dd-mm-yyyy) — —	Claim number
☐ (STD/LTD) Co. name				
☐ Other (e.g., legal action, retirement pension)				

3 Authorization

I certify that the above answers are full, complete and true.

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 collect, use and disclose 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, government agencies, provincial health care plans, institutions, investigative agencies, insurers and reinsurers including my plan sponsor's long term disability carrier. I understand that information about me pertaining to this claim may be reviewed in the event that this Plan is audited.

I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to collect, use and disclose 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.

A photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

Signature of claimant	Date (dd-mm-yyyy)
X	– –

Please use a separate sheet for additional comments

Waiver of premium claim – Summary of claimant's education, training and experience

Sun Life Financial

Member ID number	Contract number
Last name	First name

Note: This information is important to the assessment and administration of your claim. Complete in full (Attach a separate sheet if necessary.)

Please PRINT clearly.

1 Education

Highest grade level of education completed	☐ Grade 6 and under ☐ Grade 7	☐ Grade 8	☐ Grade 9	☐ Grade 10	☐ Grade 11	☐ Grade 12	☐ Grade 13						
Name of technical or trade school attended								Type of diploma obtained					
Name of college or university attended								Number of years completed					
Type of degree obtained								Name major					
Country/province where education completed													
Language	English	☐ Written ☐ Spoken		French	☐ Written ☐ Spoken			Other _____			☐ Written ☐ Spoken		

2 Training

Name technical or administrative courses taken			
Name apprenticeships completed			
List any certificates/diplomas/licences you hold and the year you obtained them			
Describe any on-the-job training (include in-service courses, "hands-on" experience, etc.)			
List any special-interest courses and where taken			
Do you have a valid driver's licence?	☐ Yes ☐ No	If *yes*,	☐ Standard licence ☐ Other (specify) _____
Are there any restrictions on your driving as a result of your medical condition?	☐ Yes	☐ No	
If *yes*, please explain			

3 Experience

Present employment

Briefly describe your duties and when you started in this job

Past employment

Please complete the following, providing details of your previous positions.

Name of plan sponsor/employer	Job title	
Duties	Duration of employment From _ _	To _ _
Name of plan sponsor/employer	Job title	
Duties	Duration of employment From _ _	To _ _
Name of plan sponsor/employer	Job title	
Duties	Duration of employment From _ _	To _ _
Name of plan sponsor/employer	Job title	
Duties	Duration of employment From _ _	To _ _
Name of plan sponsor/employer	Job title	
Duties	Duration of employment From _ _	To _ _

Job skills

What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc.) Where appropriate, give level of proficiency.

Community interests

Outline your past or present involvement with any community/church/volunteer organizations

Hobbies

Signature of claimant	Date (dd-mm-yyyy)
X	_ _

Please use a separate sheet for additional comments

4 Workers' Compensation Board authorization to release information

Contract number	Member ID number

This will authorize the Workers' Compensation Board to furnish Sun Life Assurance Company of Canada any medical, or non-medical, information necessary to the evaluation of your disability claim.

My claim number with the WCB is: _____ .

Return form to:

Sun Life Assurance Company of Canada
Group Life Claims
1155 Metcalfe St
Montreal QC H3B 2V9

Signature of claimant	Date (dd-mm-yyyy)
X	_ _