



Claim for Disability Insurance
Employee's Medical Information and Attending Physician's Statement
Policy No. 12500-G

For the Employee

To avoid delay, you must fully complete and sign Part 1 of this form, and have your doctor complete Part 2. Please keep Part 1 attached to Part 2. Your doctor should send this completed form to Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), at the address provided at the end of this form. You are responsible for the cost of completing this form.

PART 1: EMPLOYEE INFORMATION

About you

Form section for employee information including fields for Last Name, Given Name, Maiden Name, Street Address, Home Telephone No., City, Province, Postal Code, Date of Birth, Sex, and Certificate No.

About your illness or injury

Form section for illness or injury details including numbered questions 1 through 7 regarding symptoms, dates, and activities.

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About your illness or injury (continued)

8. Do you have a valid driver's licence? No
 Yes

If your driving has been restricted as a result of your illness or injury, please give details. Please also explain how you get around when you leave your house (i.e. drive, public transport, taxi, etc.).

9. Provide the names and addresses of all the doctors you consulted during your present illness or injury.

Name of doctor	Address	Date of visit

Your general medical history Attach extra sheets, if necessary.

1. List all the doctors you have consulted during the past five years.

Name of doctor	Address	Nature of illness / injury	Treatment prescribed (medicine, diet, etc.)	Date of visit / treatment

2. Please list the names and addresses of all the hospitals where you received treatment during the past five years, including any type of surgery.

Nature of illness / injury	Date of visit or confinement	Treatment or surgery (medicine, diet, etc.)	Name and address of hospital

If, as a result of any of these prior illnesses or injuries, changes in activities or work restrictions were advised, please describe what the changes were:

Employee's declaration, authorization and signature

- I certify that the statements on this form are true and complete.
- I authorize my doctor, Sun Life Assurance Company of Canada and any person or organization who has relevant personal information about me, including health professionals and institutions, investigation agencies, insurers and persons performing services for Sun Life Assurance Company of Canada, to exchange information needed for underwriting, administration or paying claims.
- I agree to a personal investigation in connection with this claim.
- I agree that a photocopy of this authorization is as valid as the original.

Employee's Signature	Date
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PART 2: ATTENDING PHYSICIAN'S STATEMENT

Medical History

Please fill in this form completely and as soon as possible to ensure that there is no delay of any payments to which the employee may be entitled. Sun Life Assurance Company of Canada (referred to in this form as the "Insurer"), will use the information on this form to determine the employee's eligibility for disability benefits. Your accurate and detailed completion of this form will help the Insurer to arrive at a just decision. The Insurer may request up-to-date medical or fitness information from you to review the employee's progress and potential to return to work. The employee is responsible for the cost of completing this form.

1.	What was the date of the patient's first appointment for this illness or injury?	Day	Month	Year
		/ /		
2.	What was the date of the patient's latest appointment?	Day	Month	Year
		/ /		
3.	Did you recommend that the patient stop work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, as of what date?
		Day	Month	Year
		/ /		
4.	How often are the patient's appointments?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Monthly
		<input type="checkbox"/> Other (Please specify.)	_____	
5.	Was the patient's illness or injury caused by an accident?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	If yes, please give the details and the date of the accident.			

6.	Describe the pertinent symptoms, their severity, their duration and their impact on the claimed disability (including the patient's ability to work).			

7.	When did the symptoms first appear?	Day	Month	Year
		/ /		
8.	Has the patient ever had a similar or related condition?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, state when and describe the condition.

9.	Is the condition due to injury or illness caused by employment?	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, give details.
		<input type="checkbox"/> Yes		

10.	Is the condition due to or related to pregnancy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, give dates of confinement.
		Day	Month	Year
	From	/	/	to
		Day	Month	Year
		/ /		
11.	How is the patient restricted or limited by the condition?			

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Medical History (continued)

12. What is the patient's current status?

<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Using a walking aid	<input type="checkbox"/> Using a wheelchair
<input type="checkbox"/> House confined	<input type="checkbox"/> Bed confined	<input type="checkbox"/> Hospital confined

13. Please indicate the patient's current height and weight.

Height:		Weight:	
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Clinical findings

Please describe the physical findings in relation to the illness or injury.

Diagnoses

What are the diagnoses that have led to the disability claim? Please list them in order of their importance to the patient's illness or injury and their impact on the claimant. If the condition is psychiatric, use DSM IV terminology.

Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the illness or injury. (Attach available consultation notes.)

Treatment

1. Was this patient hospitalized? No Yes

If yes, give dates:

From	Day	Month	Year	to	Day	Month	Year
	/	/			/	/	

2. Was surgery performed or is it scheduled? No Yes

If yes, give details:

Date	Type of Surgery

3. What medications were prescribed to the patient? Please include names, dates first prescribed, dosage and the dates of any medication changes.

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Treatment (continued)

4. Has the patient been given counselling or psychotherapy? No Yes If yes, give frequency and duration. (Attach copies of reports.)

5. Has the patient received physiotherapy/chiropractic treatment? No Yes If yes, give frequency and duration. (Attach copies of reports.)

6. What other treatments have been or are being given?

7. Please describe the result of all treatments to date.

8. To what extent has the patient complied with the treatment plan? Please explain any factors that may have prevented compliance.

9. Please give names, specialties and appointment dates of any consulting physicians or health care professionals such as psychologists. (Attach copies of consultation notes.)

Name and Address	Specialty	Appointment date

Cardiac Complete if applicable.

1. What is the functional capacity (American Heart Association)? If Class 3 or 4, please include a copy of stress test or cardiac echogram.

Class 1 (no limitation) Class 2 (slight limitation)
 Class 3 (marked limitation) Class 4 (complete limitation)

2. What is the latest blood pressure reading for the patient?

3. Date blood pressure reading recorded: _____ Day _____ Month _____ Year _____
/ / /

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Additional information

- | | | |
|-----------|--|---|
| 1. | In your opinion, does the patient have any physical or mental limitations that would prevent him/her from handling his or her own financial affairs?

If yes, give details of any physical or mental limitations.

_____ | <input type="checkbox"/> No
<input type="checkbox"/> Yes |
| 2. | Would further communication with the Insurer's Medical Director be beneficial? | <input type="checkbox"/> No
<input type="checkbox"/> Yes |
| 3. | Would it be helpful for you to speak with a Rehabilitation Specialist representing the Insurer? | <input type="checkbox"/> No
<input type="checkbox"/> Yes |

Physician information

Name (Please print.)		
Street Address		
City	Province	Postal Code
Specialty	Telephone No. ()	Fax No. ()

Physician Signature

Signature	Date
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To keep this document confidential, please send this form
to the Sun Life Assurance Company of Canada Claims
Office listed below:

Montreal Group Disability Management Office
Federal Government Disability Insurance Plan
PO Box 12500 Stn CV
Montreal, QC H3C 5T6

Provision of the information requested in this form is voluntary. The information is being collected by the Insurer for the purpose of the administration and the assessment of claims under the Disability Insurance Plan. This information is essential to the Insurer's decision concerning this claim. Refusal to respond fully may result in disability benefits not being approved. All information provided is strictly confidential, for use by the Insurer, in connection with the Disability Insurance Plan.