Sun Life Assurance Company of Canada

Long-Term Disability Claim Packet – Attending Physician

Instructions for the Attending Physician

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

The Attending Physician must:

☐ Complete, sign and date the Attending Physician's Statement

☐ Submit the Attending Physician's Statement directly to Sun Life Financial

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 – Attending Physician

Fraud Warnings

State law requires that we notify you of the following:

General 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.

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.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, MA, MN, NM, RI, 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.

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.

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.

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.

DC: 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.

DE, ID, and IN: 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.

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.

KS: 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 may be guilty of insurance fraud as determined by a court of law.

Fraud Warnings continued

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: 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.

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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

OK: WARNING: 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.

OR and VA: 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.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN and WA: 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.

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

Long-Term Disability Claim Packet – Attending Physician

Attending Physician's Statement – Physical conditions only

Group policy number
901197

1 Patient Information

Please print clearly

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

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Do you believe this patient is competent to endorse checks? ..... ☐ Yes ☐ No		

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Primary diagnosis	
Secondary diagnosis	
Objective findings/investigative testing (i.e., x-rays, EKGs, MRIs, laboratory data, etc.)	
Subjective symptoms	
Date symptoms first appeared or date of accident	If injury is due to a motor vehicle accident, indicate in which state the accident occurred.
Is condition due to injury/sickness arising out of patient's employment? ... ☐ Yes ☐ No ☐ Unknown	
Names and addresses of other treating physicians (if applicable)	
If pregnancy, please provide the following information: • Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No	

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit	Date of most recent visit	Blood pressure
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☐ Other (please specify: _____)		
Description of Treatment		

4 Progress

Patient: ☐ Unchanged ☐ Improved ☐ Retrogressed ☐ Ambulatory ☐ Bed confined

If retrogressed, please explain:		
Has patient been hospital confined? ..... ☐ Yes ☐ No	From:	To:
If yes, provide name of hospital, address and dates of confinement		

5 Restrictions and Limitations

Restrictions: What activities your patient **should not** do
Limitations: What activities your patient **cannot** do

Patient's dominant hand is: ☐ Left ☐ Right

Patient is able to use hand for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulation	Key Boarding
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

In a typical work day, patient is able to: **(This is not considered an FCE)**

	Continuously	Frequently	Occasionally	Negligible
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Lift	☐ _____ lbs.	☐ _____ lbs.	☐ _____ lbs.	☐ _____ lbs.
Carry	☐ _____ lbs.	☐ _____ lbs.	☐ _____ lbs.	☐ _____ lbs.

Is the patient able to drive during a typical work day? ..... ☐ Yes ☐ No

5 Restrictions and Limitations continued

Physical Impairment

- ☐ No limitation of functional capacity – (no restrictions)
- ☐ Medium capacity – (lifting, carrying, pushing, pulling 20-50 lbs. occasionally; 10-25 lbs. frequently; or up to 10 lbs. constantly)
- ☐ Light capacity – (lifting, carrying, pushing, pulling 20 lbs. occasionally; 10 lbs. frequently; or negligible amount constantly. Can include walking and/or standing frequently even if the weight is negligible. Can include pushing or pulling of arm or leg controls.)
- ☐ Sedentary capacity – (lifting, carrying, pushing, pulling 10 lbs. occasionally. Mostly sitting, may involve standing or walking for brief periods of time.)
- ☐ Comments (please explain):

Cardiac (if applicable) - Functional capacity (American Heart Association)

☐ No limitation ☐ Slight limitation ☐ Marked limitation ☐ Complete limitation

6 Prognosis

How long will those limitations apply? (estimated)

☐ 6-8 weeks ☐ 8-12 weeks ☐ 12-26 weeks ☐ Expected recovery date: _____

☐ No recovery expected

7 Remarks

Please use this space for any additional comments.

If needed, what would be a convenient day/time of day for our benefits administrator or medical doctor consultant to call you? _____

8 Certification and Signature

Remember to provide your full address, phone number, and Tax ID number. **A stamp or signature of a person other than the examining physician, physician's assistant, or nurse practitioner is not acceptable.**

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)		Degree/Specialty	
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Please be sure to return the completed Attending Physician's Statement to:

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

Sun Life Assurance Company of Canada

Long-Term Disability Claim Packet – Attending Physician

Attending Physician's Statement – Behavioral health conditions only

Group policy number
901197

1 Patient Information

The patient is responsible for any expense involved in the completion of this form. Please be sure to respond to all items as specifically and completely as possible.

Please print clearly

Name of patient (first, middle initial, last)		☐ M ☐ F
Claimant control number	Social Security number	Date of birth (m/d/y)

Use current DSM.

_____

_____

_____

2 Treatment Information

Date of first signs of illness	Date of first exam	Date of recent exam
Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify):		

Has the patient ever had a psychiatric hospitalization, partial hospitalization, intensive outpatient treatment? ..... ☐ Yes ☐ No

Facility name	Address	Admission date	Discharge date

Describe the patient's initial reason for seeking treatment. Specify how and when the symptoms first appeared and the progression of symptoms to current level.
Describe the patient's current symptoms.
Have any quantitative evaluations of functional impairment been performed?..... ☐ Yes ☐ No If yes, please list the psychological/neuropsychological testing performed and provide copies of the test and the raw data. If no, have any evaluations been planned? Specify scheduled dates, if any.
Describe the patient's mental status.
Describe if/how the patient's psychiatric condition is limiting the patient's functional capacity.

2 Treatment Information continued

Degree of impairment
0 = None – no impairment in this area
1 = Slight – suspected impairment of slight importance that does not affect functional ability
2 = Moderate – impairment that affects but does not preclude ability to function
3 = Severe – extreme impairment of ability to function

Comments (please explain):

Activity	Degree of impairment	Comments
Interpersonal relations	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Daily activities (e.g. hygiene, shopping, household chores, caring for children)	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Occupational/social (e.g., respond appropriately to supervision, supervise or manage others)	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Ability to think/reason	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Understand and carry out instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Sustain work performance	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Attention span	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Concentration	☐ 0 ☐ 1 ☐ 2 ☐ 3	
Past/present memory disturbance	☐ 0 ☐ 1 ☐ 2 ☐ 3	

Do you feel that the patient's condition is precipitated by a situation at their place of employment?
☐ Yes ☐ No

If yes, please provide the details of the employment situation.

Are the patient's problems related to alcohol or drug abuse? ..... ☐ Yes ☐ No

If yes, please specify, including onset, severity, types of drugs used, and prior treatment.

Is return-to-work part of your treatment plan? ..... ☐ Yes ☐ No

Please provide estimated return-to-work date _____ ☐ Part-time ☐ Full-time

Specify any other factors that may have precipitated and could influence recovery and return to work. (e.g. family history, effects of physical illness, psychological history, educational history, inability to tolerate medications, legal or licensing difficulties, financial difficulties, occupational issues, etc.)

2 Treatment Information continued

Has this patient ever suffered from symptoms of the same, similar or other mental or emotional disorder in the past? ..... ☐ Yes ☐ No ☐ Don't know

If yes, please provide details, including previous treatment, names and addresses of providers, and patient's response to treatment.

Please provide a list of medication.

Medication	Dosage	Date Started	Response	Date Discontinued

Is the patient capable of managing his/her financial affairs? ..... ☐ Yes ☐ No

If yes, do you believe this patient is competent to endorse checks? ..... ☐ Yes ☐ No

3 Certification and Signature

Remember to provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

Attached is the claimant's signed authorization form for release of records. Please attach copies of all treatment notes, including initial evaluation, with the submission of this statement.

You may be contacted to further discuss or clarify the claimant's psychiatric information.

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)		Degree/Specialty	
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Please be sure to return the completed Attending Physician's Statement to:

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