

# Attending Physician's Statement Short-Term Disability Claim



## Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada in making a decision on your patient's claim for disability benefits.

## Return address

Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Assurance Company of Canada Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

### Edmonton:

Fax: 1-866-639-7820

PO Box 2733 Stn Main

Edmonton AB T5J 5C9

### Toronto:

Fax: 1-866-639-7851

PO Box 950 Stn A

Toronto ON M5W 1G5

### Halifax:

Fax: 1-866-639-7850

PO Box 11480 Stn CV

Montreal QC H3C 5P5

### Montreal:

Fax: 1-866-639-7846

PO Box 11037 Stn CV

Montreal QC H3C 4W8

### Kitchener - Waterloo:

Fax: 1-866-209-7215

PO Box 100 Stn C

Kitchener ON N2G 3W9

### Vancouver:

Fax: 1-866-639-7829

PO Box 48810 Stn Bentall

Vancouver BC V7X 1A6

## 1 Plan Member information and authorization to be completed by patient

Last name (Quebec residents – maiden name)		First name		Home telephone number — —		Alternate telephone number — —	
Address (street number and name)						Apartment or suite	
City				Province		Postal code	
Plan Sponsor name				Contract number		Member ID number	
Height	Weight	Date of birth (dd-mm-yyyy) — —	Last date worked (dd-mm-yyyy) — —	Date returned to work or expected return to work date (dd-mm-yyyy) — —			

I authorize my doctor to collect, use and disclose my personal information to Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature X	Date (dd-mm-yyyy) — —
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## 2 Attending Physician's Statement

**Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Page 1 only AND SIGN THE ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT AT THE END OF THIS FORM. For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

### Diagnosis

Primary:

Secondary:

If childbirth: expected or actual delivery date (dd-mm-yyyy)

☐ Vaginal

☐ C-Section

**Occupational illness/injury** Is condition arising from employment? ☐ Yes ☐ No

### Start dates of current work absence

Date of first visit during current period of absence (dd-mm-yyyy)

First date of work absence due to condition (dd-mm-yyyy)

### Hospitalization

Has your patient been hospitalized?

☐ Yes

☐ No

Date admitted (dd-mm-yyyy)

Have they had day surgery?

☐ Yes

☐ No

Date discharged (dd-mm-yyyy)

Name of institution:

If surgery was performed, please provide date and description of surgery

Date (dd-mm-yyyy)

Description

Type of anaesthetic

### Treatment (Drug, dosage, physiotherapy, other)

### Prognosis – Please provide the prognosis for recovery