

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet - Claimant



Instructions

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 Claimant's Statement directly to Sun Life Financial.

The Claimant must:

Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**

- Employer Statement
- Claimant Statement
- Attending Physician Statement
- Authorization Statements

An STD claim should be submitted for a disability absence that may extend beyond the required elimination period.

Have the physician must completely fill out and sign the Physician Statement.

Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim or check on a status online go to www.sunlife.com/us.

- Click on "Submit a Disability Claim"
- OR Fax to: **781-304-5599**

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet - Claimant



Claimant's Statement

Group STD policy number

1 General Information

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employee (first, middle initial, last)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)
Employee street address	City	State	Zip code
Home phone:	Preferred form of contact:		
Cell phone:	<input type="checkbox"/> Home phone	<input type="checkbox"/> Cell phone	
Work phone:	<input type="checkbox"/> Work phone	<input type="checkbox"/> Mail	
Name of employer (parent company name)			

2 Information About the Condition Causing Your Disability

Last day worked before disability	Date first treated by Physician	Date expected to return to work <input type="checkbox"/> FT <input type="checkbox"/> PT
Did you require Emergency Room care for your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Hospital name:		
Date:	Phone:	
Were you confined to a hospital for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, include the hospital name		Hospital phone
Date(s) of confinement: From: To:		

Select the appropriate type of condition, and provide details:

<input type="checkbox"/> Pregnancy
Expected due date: _____ Actual due date: _____
Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section
Complications: _____
<input type="checkbox"/> Work-related injury/sickness
Date of first symptom/injury: _____
Where occurred: _____
Cause of injury/sickness: _____
Do you intend to file for Workers Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the status: <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Appealed
<input type="checkbox"/> Sickness First date of symptom: _____
Type of sickness: _____
Have you experienced a symptom in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____

2 Information About the Condition Causing Your Disability continued

<input type="checkbox"/> Motor vehicle accident - complete only if applicable	
Date occurred:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Was a citation issued to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, type of citation:	
How injury occurred:	
Where injury occurred:	
Name of your car insurance carrier:	
Phone number:	
Are you receiving compensation from a car insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Date: From:	To:
<input type="checkbox"/> Other injury	
Date occurred:	Where occurred:
How occurred:	
Describe type of injury:	

3 Information About Other Income

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

<input type="checkbox"/> Sick pay/Salary continuance	<input type="checkbox"/> State Disability	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Other:		

4 Physician Information

Indicate physicians you are seeing or have seen for this condition.

Name of physician:	Phone:
Specialty:	Fax:
Name of physician:	Phone:
Specialty:	Fax:

5 Signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Employee's signature X	Date signed
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Sun Life Assurance Company of Canada

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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—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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 warning—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.

Fraud warning—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.

Fraud warning—ME, 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.

Fraud warning—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.

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

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

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 STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care 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, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

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 I have a pending Family and Medical Leave Act (FMLA) claim, I authorize the Company to disclose to FMLASource, the FMLA claim administrator, any information it obtains about me or from me. I also authorize FMLASource to disclose to the Company any information it obtains about me or from me in connection with my FMLA claim.

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 re-disclosed 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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Short Term Disability Claims, SC3212, 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 STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care 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, health care professional, hospital, clinic, medical facility or other health care 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) 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 I have a pending Family and Medical Leave Act (FMLA) claim, I authorize the Company to disclose to FMLASource, the FMLA claim administrator, any information it obtains about me or from me. I also authorize FMLASource to disclose to the Company any information it obtains about me or from me in connection with my FMLA claim.

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice Sun Life Financial, Group Short Term Disability Claims, SC3212, 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 STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager 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.

If I have a pending Family and Medical Leave Act (FMLA) claim, I authorize the Company to disclose to FMLASource, the FMLA claim administrator, any information it obtains about me or from me. I also authorize FMLASource to disclose to the Company any information it obtains about me or from me in connection with my FMLA claim.

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice Sun Life Financial, Group Short Term Disability Claims, SC3212, 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

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 on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-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 and
- 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, and
- 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, and
- 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 Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481