Sun Life and Health Insurance Company (U.S.)
Life benefits claims packet – Attending Physician

Use this claims packet for the following:

- waiver of premium benefits—totally disabled without further premium payments
- accelerated benefits—terminal illnesses and qualifying events
- accidental dismemberment benefits—accidental bodily injury or loss
- permanent total disability benefits—permanently and totally disabled

Instructions for the attending physician

In the event of illness, dismemberment, or disability of an insured, please follow these steps as soon as you determine whether the insured is eligible for accelerated benefits, waiver of premium benefits, permanent total disability benefits and/or accidental dismemberment benefits.

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

☐ mail or fax the completed attending physician statement directly to:

Sun Life and Health Insurance Company (U.S.)
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Tel: 800-247-6875
Fax: 888-551-2084

Failure to provide complete and accurate information could result in the need for an additional claims investigation, which could delay the initial benefit payment or the approval of the waiver of premium.

Sun Life and Health Insurance Company (U.S.)
Life benefits claims packet – Attending Physician

Attending physician's statement—physical conditions only

It is the responsibility of the employee to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

1 Information about the patient

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

Please print clearly.

Name of patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Patient's home address	City	State / Zip code
Name of employer	Group policy number	Employee phone no.

Do you believe this patient is competent to endorse checks? ..... ☐ Yes ☐ No

2 Diagnosis and history

Provide general information about diagnosis, treatment, doctor's notes, and history in this section.

Diagnosis, including any complications and ICD-9 codes(s)

For accelerated benefits only—if the patient has a terminal illness, please indicate the life expectancy:_____ Months ☐ N/A

Other qualifying events (if applicable): ☐ Loss of two or more Activities of Daily Living

☐ Major organ transplant (please describe):

☐ Cognitive impairment (please describe):

☐ Medical condition requiring continuous artificial life support (please describe):

☐ Permanent neurological deficit resulting from a cerebral vascular accident (please describe):

Include objective findings (i.e., X-rays, EKGs, MRIs, laboratory data, and any other clinical findings) ☐ N/A

Subjective findings ☐ N/A

Date symptoms first appeared or accident occurred (m/d/y) ☐ N/A	Date disability commenced (m/d/y) ☐ N/A

If injury due to a motor vehicle accident, indicate the state in which the accident occurred.

Patient's height:	Patient's weight:	Blood pressure:

Is condition due to injury/sickness arising out of patient's employment? ☐ Yes ☐ No

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

Describe any complications that would extend this disability longer than a normal pregnancy.

3 Treatment

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

Date of first visit ☐ N/A	Date of last visit ☐ N/A	Date of last examination ☐ N/A
Frequency of treatment..... ☐ Weekly ☐ Monthly ☐ Other (please specify: _____)		
Description of treatment		

4 Progress

Patient's progress: ..... ☐ Unchanged ☐ Retrogressed ☐ Improved ☐ Recovered

Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain		
If patient has been hospital confined, give dates	From:	To:
Provide name and address of hospital (if applicable)		

5 Limitations

Please note that additional occupational information may be required.

Patient may use hands for repetitive actions such as:

	Simple grasping		Firm grasping		Fine manipulating	
Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Patient may use feet for repetitive movement, as in operating foot controls ..... ☐ Yes ☐ No

During the day, is the patient able to:

	67%–100%	34%–66%	1%–33%	0%
Drive	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist body	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Grasp	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Lift _____lbs.	☐	☐	☐	☐
Carry _____lbs.	☐	☐	☐	☐

Is the patient capable of working within these restrictions/limitations?..... ☐ Yes ☐ No

Can the employee work an 8-hour day with the above restrictions? ..... ☐ Yes ☐ No

If not, how many hours could he or she work with the above restrictions? _____

6 Physical impairment

☐ No limitation of functional capacity; capable of heavy work*..... No restrictions (0%–10%)
☐ Medium manual activity* .....(15%–30%)
☐ Slight limitation of functional capacity; capable of light work*.....(35%–55%)
☐ Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary*) activity.....(60%–70%)
☐ Severe limitation of functional capacity; incapable of minimum (sedentary*) activity.....(75%–100%)

* As defined in the *Federal Dictionary of Occupational Titles.*

7 Cardiac (if applicable)

Functional capacity (American Heart Association)

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

Therapeutic class (activity)

☐ No restriction ☐ Slight restriction ☐ Marked restriction ☐ Complete restriction

Blood pressure—last visit _____

8 Work capabilities

Is patient capable of working within these limitations? ..... ☐ Full time ☐ Part time
Is patient capable of another occupation on a full-time basis? ..... ☑ Yes ☐ No
Is patient capable of another occupation on a part-time basis? ..... ☑ Yes ☐ No

9 Prognosis

How long will those limitations apply? (estimate)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

10 Certification and signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician 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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Name of attending physician		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Telephone number	Fax number	
Signature of attending physician X		Date	

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Life benefits claims packet – Attending Physician

Attending physician's statement—behavioral health conditions only

It is the responsibility of the employee to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

Group policy number

1 Patient information

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

Please print clearly.

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		

- ☐ Patient is able to function under stress and engage in interpersonal relations (no limitation)
- ☐ Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
- ☐ Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
- ☐ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
- ☐ Patient has significant loss of psychological, physiological, personal, and social adjustments (severe limitation)

In order to evaluate a claim for disability benefits submitted by your patient, we need more detailed information about his or her medical condition. Please provide the following information.

Use current DSM.

_____

_____

_____

2 Treatment information

When did the patient first experience psychiatric symptoms?
What was the first date you treated the patient for symptoms?
Name of first treating physician for symptoms (first, middle initial, last)
Please list facilities and dates of any hospitalization, intensive outpatient program, or partial hospitalization program.
What was the diagnosis at that time?

2 Treatment information, continued

Current diagnosis
Describe the patient's current psychiatric symptoms and mental status evaluation.
Is the patient's current condition related to chemical dependency? ..... ☐ Yes ☐ No If yes, please describe

Has there been any psychological testing? If available, provide results. If not, why? Are there any plans in the future to perform testing?
Describe the current treatment methods/treatment plan.
List medications with dosages. Please note any recent changes.
Please describe patient's response to treatment to date. (Include any past treatments and additional methods of treatment being considered.)
Please describe if the patient's psychiatric condition is limiting the patient's functional capacity.

3 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

4 Certification and signature

Please provide your full address and Tax ID number.

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Name of attending physician		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Telephone number	Fax number	
Signature of attending physician X		Date	