Salary Continuance Services
Plan Member Package

How to use this package:

REVIEW	• The links below will take you to the Salary Continuance Services Plan Member Guide, a Plan Member's Statement and an Attending Physician's Statement included in this package. • The "Return to Introductory Page" link on each document will take you back to this page. • Read the Authorizations on both the Plan Member's Statement and Part 1 of the Attending Physician's Statement.
COMPLETE	• You are able to save information typed into the forms included in this package. • Complete the Plan Member's Statement in its' entirety. • Complete Part 1 (Plan Member Information) on the Attending Physician's Statement.
PRINT	• Print the complete Plan Member's Statement and sign the Authorization. • Print the Attending Physician's Statement with Part 1 completed, sign the Authorization and have your physician or specialist complete the form in its entirety.
SUBMIT	• Send in your completed forms using one of the options provided on the last page of the Plan Member Statement.

- Salary Continuance Services – Plan Member Guide
- Plan Member's Statement for Salary Continuance Services
- Attending Physician's Statement for Salary Continuance Services

SALARY CONTINUANCE SERVICES

Plan Member Guide

Everything you need to know to report your absence

Welcome

Your employer has asked us to help you through the process of reporting your absence, applying for salary continuance and making plans for returning to work. Because every situation is unique, we treat each absence individually, and we're here to help in any way we can. While you'll have support from your doctor, your employer and Sun Life, the most important person involved is you!

Sun Life Financial and your employer want to help you return to health and work as soon as it is safe for you to do so. You probably have lots of questions: this guide will answer many of them and, later on, your Abilities Case Manager will be glad to answer any others as you go along.

To report your absence and apply for salary continuance while you're off work, you and your employer will need to send us the following completed statements:

- **A Salary Continuance Services Plan Sponsor's Statement**, which your employer completes and faxes to us.
- **A Salary Continuance Services Plan Member's Statement** (enclosed with this guide), which you must complete and fax or mail to us. The Sun Life fax numbers and addresses are shown on the form.
- **Attending Physician's Statement** (enclosed with this guide), which you take to your doctor to complete and fax to us. **NOTE:** If your doctor charges you a fee to complete this form, you will be responsible for paying the fee.

The salary continuance plan is provided by your employer with case management services provided by Sun Life.

Return to Introductory Page

Sun Life Financial

Reporting your absence

1. Complete and fax your Plan Member's Statement

This statement provides us with information about your condition, how it occurred, your general medical history, and your expected sources of income and benefits while you're on leave.

- Be sure to answer all the questions in full to avoid delays when we assess your absence, and include a detailed job description and résumé with previous job experience and education history. You can attach extra paper to the statement if you need more space.
- Be sure that all dates provided (date you were first unable to work, date of accident, etc.) are correct since they are essential to our assessment.
- Please read and **sign the Declaration and Authorization** which allows us to exchange information with your doctor and any other health care professionals who are involved in your care. This is necessary for us to advise your employer if your absence is supported for salary continuance.
- Please sign Part 1 of the Attending Physician's Statement before giving the form to your physician to complete.
- Fax us your completed Plan Member's Statement within the time set by your plan sponsor in their absence policies and procedures. If you're unsure of how much time you have, ask your manager.

2. Have your physician complete the Attending Physician's Statement

This statement provides us with specific medical information about your condition and your expected recovery.

- Your doctor's Attending Physician's Statement must provide a diagnosis and prognosis for your condition. This form can be filled out by your family doctor, a doctor at a walk-in clinic, a specialist, etc. – any medical professional who is a doctor of medicine and who has treated you for your condition.
- If your doctor conducts tests, all of the findings must be included on or with the Statement.
- If your absence is due to a **mental health condition**, be sure to have your physician send us copies of all consultation and clinical notes with his or her Statement. Often, we must follow up to request these documents which can delay the assessment of your absence.
- Follow up with your doctor and employer to confirm they have completed, signed and faxed us their Statements (Plan Sponsor, Plan Member and Attending Physician).

NOTE: Do not change or write anything on the Attending Physician's Statement. Any changes to the Statement must be initialed by your doctor.

Be sure your group contract number and your Member ID number are clearly shown on your Plan Member's Statement and Attending Physician's Statement before faxing/mailing. If you are unsure, please contact your Benefits Administrator who will be able to provide you with this information.

Salary continuance

An Abilities Case Manager will be assigned to you once we receive your Plan Member's Statement and your employer's Plan Sponsor's Statement. He or she will assess the information we receive about your absence, including the medical information, information about your ability to function and carry on daily living activities, your job demands, your work environment, etc. We may need to contact you, your doctor and/or your employer by phone or in person to ask questions or obtain any missing information. Once the assessment is complete (usually about five business days after we receive all the necessary information), your Abilities Case Manager will write to you and your employer to confirm that:

- Your absence is medically supported, based on the information submitted; or
- Your absence is not medically supported, based on the information provided; or
- The information provided is not sufficient for us to assess whether your absence is medically supported, and we will ask you to provide further information.

Return to Introductory Page

What happens next?

If your absence is medically supported during the salary continuance period, we will continue to monitor your condition while you are away from work. We will ask you for medical updates from your doctor from time to time (frequency will depend on your medical condition, treatment plan, progress, etc.). And you will be expected to follow your doctor's treatment advice as well as our return-to-work plan if one is presented to you.

Your information is confidential

We treat the information you provide to us as confidential. We only collect, use, and disclose information about you as outlined in the authorization you have signed on your Plan Member's statement, or as permitted or required by law.

We will only advise your employer about limitations or restrictions that affect your ability to do your job (as outlined in the Acknowledgment you signed on your Plan Member's Statement).

FAQs

We want you to feel comfortable with the salary continuance absence submission process. The following Frequently Asked Questions are designed to help you understand more about the process, from absence submission through to your recovery and return to work.

What do 'plan sponsor' and 'plan member' mean?

The term 'plan sponsor' is another name for your employer, the policy holder or the contract holder for your health benefits plan. The 'plan member' is another name for the employee.

What are my Contract, Division and Member ID numbers?

The Plan Member's Statement asks for your Contract number, Member ID and Division/Billing number. The Contract and Division numbers are specific to your plan sponsor/employer's coverage with Sun Life Financial. The Member ID number is the number used to identify you specifically. These numbers can be found on your coverage card and should be added to your forms by your plan sponsor. If you are unsure, please contact your Benefits Administrator.

Why should my doctor fill out all the information on my form?

To quickly assess your absence, it is very important to have all of the information requested. If your doctor provides only part of the information, or a note on a doctor's prescription pad, we will likely not have all of the information needed to assess your request for benefits, or an extension of benefits. This will potentially delay a decision about your absence.

Can Sun Life stop my salary continuance?

Sun Life cannot stop your salary continuance directly, but we will advise your employer whether your absence from work is medically supported. If the information we receive from you, your plan sponsor, and your physician does not show that you are unable to perform the essential duties of your job, or if you don't provide medical information to support your absence, our advice to your employer may be that your application for salary continuance should not be supported.

Can Sun Life tell me what treatment to have if I'm ill or injured?

No. Sun Life does not tell you what your treatment should be, but we will review your doctor's treatment plan and compare it with generally accepted medical guidelines for your condition. Your Abilities Case Manager will work with your doctor and/or our Health Partners to determine that you are receiving appropriate treatment. In some cases, we may require that you undergo an independent medical exam (IME) through our network of health service professionals across the country, to get more information. We will arrange such an appointment and give you adequate advance notice. We will provide a copy of the results to your treating physician.

Does Sun Life share medical information with my employer?

No. All medication, diagnosis and treatment information obtained by Sun Life concerning your health is strictly confidential and not shared with anyone at your employer unless specifically outlined in the authorization you have signed on your Plan Member's Statement.

We do not share medication, diagnosis and treatment information with your manager or Human Resources department at work.

Return to Introductory Page

Plan Member's Statement
Salary Continuance Services

Sun Life Financial

Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

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1 Plan Member information

In order to avoid any delays in the assessment of your absence, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this absence will be your responsibility.**

First name	Last name	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Address (street number and name)			Apartment or suite
City		Province	Postal code
Occupation	Job title		
Home telephone number	Alternate telephone number		
What province were you living in at the time your coverage became effective under this plan?	Preferred language of correspondence ☐ English ☐ French		

If you would like Sun Life to email you, please fill in your email address below. By giving us your email address, you are allowing Sun Life to communicate with you at this address, and acknowledge that the security of the email communication cannot be guaranteed.

Email address

2 Plan Sponsor information

Contract number	Member ID	Company name	
Contact person		Contact person email	Contact person phone number

3 About your illness or injury

You must notify Sun Life Assurance Company of Canada if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

1. Please describe your present illness or injury and how it occurred.

2. When did your symptoms first appear? Date (dd-mm-yyyy)

3 About your illness or injury (continued)

3. Have you ever had the same or similar illness or injury? ☐ No ☐ Yes If yes, please explain and give dates.

4. Is your condition related to pregnancy? ☐ No ☐ Yes If yes, what is your delivery date? Date (dd-mm-yyyy)
   Please describe your complications, if any.

5. From what date did your illness or injury prevent you from working? Date (dd-mm-yyyy)

6. Please include a list of the duties of your job that you are unable to do.

7. What treatments are you presently receiving? (Medications, physiotherapy, psychotherapy, etc..)

8. List all the doctors you have seen for *this* illness or injury and any doctors you plan to see in the near future about *this* illness or injury.

Doctor	Address	Date of visit (dd-mm-yyyy)

Please include copies of any physician reports, specialist reports, test results or investigations you've had done. If you've had any genetic testing completed, please do not include this information as it is not required for our assessment of disability.

3 About your illness or injury (continued)

9. When do you expect to be able to return to work? Date (dd-mm-yyyy) ☐ Full-time ☐ Part-time

10. Have you tried to return to work already? ☐ No ☐ Yes If yes, please answer the following questions.

What were the dates that you returned to work? From Date (dd-mm-yyyy) to Date (dd-mm-yyyy)

Did you return to: ☐ your own job ☐ new job or modified duties

Did you return to: ☐ full-time ☐ part-time

4 Disability as a result of an accident

1. Is your disability the result of an accident?

☐ No If no, continue with the next section **"Your declaration and authorization"**.

☐ Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy)	Time	Location

2. Were you working for your employer at the time of the accident? ☐ Yes ☐ No Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident? ☐ No ☐ Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number

5 Your declaration and authorization

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

I certify that the statements in this form are true and complete.

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my absence(s) from work. I authorize Sun Life to collect, use and disclose information needed for administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan ("this Plan") to any person or organization who has relevant information pertaining to my absence(s) from work including health professionals, institutions, investigative agencies, insurers and, where applicable, my Plan Sponsor. I agree that Sun Life and my Plan Sponsor may also share financial information related to my absence(s) from work for purposes relevant to the management of this Plan. I understand that information about me pertaining to my absence(s) from work may be reviewed in the event that this Plan is audited.

I authorize Sun Life to collect from and discuss with my Plan Sponsor any information in my Plan Sponsor's file (including diagnosis, treatment or medication) pertaining to my absence(s) and to use such information for the purposes described in the paragraph above.

I also authorize Sun Life and my Plan Sponsor to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **except** for details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I also authorize Sun Life and my Plan Sponsor's medical consultants to collect, use and disclose between them additional information about me that is not in my Plan Sponsor's file, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **including** details relating to diagnosis, treatment or medication, that is relevant to my absence(s) from work, for the purpose of facilitating in the resolution of any litigation or any other formal legal proceeding (threatened or actual) relating to my absence(s) from work that I may raise or commence against my Plan Sponsor.

I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work 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.

Any reference to Sun Life or my Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

Member's last name (please print)	First name (please print)	
Signature X		Date (dd-mm-yyyy)

Please notify Sun Life Assurance Company of Canada and your Plan Sponsor of your expected return to work date.
Instructions on how to submit your completed form(s) can be found on the next page

6 How to submit your completed form(s)

You have multiple ways of submitting your completed claim forms to us, along with any other information in support of your claim you would like to submit. For all options, except for mail, you can keep the original copies for your records.

If your plan has provided access to the Sun Life mobile app, you can submit your completed forms through the 'Documents' feature.

You can also send in your disability claim forms directly to Sun Life by email. If you would like to use this option, you can email us your completed disability claim forms to *disabilityclaims@sunlife.com*. Please be advised that although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, the privacy or security of email communications cannot be guaranteed.

You can fax your completed claim forms to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. If you are unable to fax this information, you can mail it to the appropriate address. If you are not sure which office to send your information to, please contact your Benefits Administrator.

Halifax:
Fax: 1-866-639-7850
PO Box 11480 Stn CV
Montreal QC H3C 5P5

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9

Montreal:
Fax: 1-866-639-7846
PO Box 11037 Stn CV
Montreal QC H3C 4W8

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

Vancouver:
Fax: 1-866-639-7829
PO Box 48810 Stn Bentall
Vancouver BC V7X 1A6

7 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Attending Physician's Statement
Salary Continuance Services

Sun Life Financial

Purpose of Statement

This Statement is to assist Sun Life Assurance Company of Canada in assessing your patient's absence from work.

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:	Toronto:	Halifax:	Montreal:	Kitchener - Waterloo:	Vancouver:
Fax: 1-866-639-7820	Fax: 1-866-639-7851	Fax: 1-866-639-7850	Fax: 1-866-639-7846	Fax: 1-866-209-7215	Fax: 1-866-639-7829
PO Box 2733 Stn Main	PO Box 950 Stn A	PO Box 11480 Stn CV	PO Box 11037 Stn CV	PO Box 100 Stn C	PO Box 48810 Stn Bentall
Edmonton AB T5J 5C9	Toronto ON M5W 1G5	Montreal QC H3C 5P5	Montreal QC H3C 4W8	Kitchener ON N2G 3W9	Vancouver BC V7X 1A6

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1 Plan Member information and authorization to be completed by patient

Last 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 information with Sun Life Assurance Company of Canada, its agents and service providers for the purposes of administration and adjudicating my absence(s) from work under my Plan Sponsor's salary continuance sick-leave plan (the "Plan"). I agree that this authorization is valid throughout the duration of my absence(s) from work or during the resolution of any decision relating to my absence(s) from work 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	Date (dd-mm-yyyy)
X	

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 up to the end of Section 2 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 all sections 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) _____

Return to Introductory Page

2 Attending Physician's Statement (continued)

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

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) _____

Visits – Frequency of visits ☐ Weekly ☐ Monthly ☐ Other _____

Symptoms – Describe current symptoms, severity and frequency.

Investigations – Please attach copies of all relevant:

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Please note that Genetic testing information is not required , so please do not include.

Are tests/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy) _____

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ Specialty _____ Date of visit (dd-mm-yyyy) _____

Restrictions and limitations – Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

Return to Introductory Page

4 Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in a group disability benefits file with Sun Life Assurance Company of Canada and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

<table>
<tr><td>Last name of attending physician (please print)</td><td>First name</td><td colspan="2">Certified specialist</td><td rowspan="5">Physician's stamp</td></tr>
<tr><td colspan="4">Address (street number and name)</td></tr>
<tr><td colspan="2">City</td><td>Province</td><td>Postal code</td></tr>
<tr><td colspan="2">Telephone number</td><td colspan="2">Fax number</td></tr>
<tr><td colspan="4">Physician's signature
X</td><td>Date signed (dd-mm-yyyy)</td></tr>
<tr><td colspan="5">NOTE: Your patient is responsible for any charge made for the completion of this form.</td></tr>
</table>