# Sun Life Assurance Company of Canada

## Group Life Claim

## Section A: Employer's Statement

Sun Life Financial

### 1. Information About the Employer

Please PRINT clearly.

Return to:
Sun Life Assurance Company of Canada
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

| Employer's Name | Group Policy Number | Subdivision | Class |
|---|---|---|---|
| Employer Contact (name of person completing this form) | Title | | |
| Employer's Street Address | City | State | Zip Code |
| Employer's Email Address | Telephone Number | Fax Number | |
| Name and Address of Division Where Employee Works (if different from above) | | | |

### 2. Information About the Employee

| Employee's Name (first, middle initial, last) ☐ Male ☐ Female | Social Security Number | Date of Birth (m/d/y) |
|---|---|---|
| Employee's Street Address | City | State | Zip Code |

### 3. Information About the Dependent

Complete only if submitting a Dependent Claim.

| Dependent Name (first, middle initial, last) | Date of Birth (m/d/y) | Relationship to Employee |
|---|---|---|

### 4. Type and Amount of Claim

Check all that apply.

| | | Basic | Optional |
|---|---|---|---|
| ☐ Life | Date of Death (m/d/y) | $ | $ |
| ☐ Dependent | Date of Death (m/d/y) | $ | $ |
| ☐ Accidental Death | Date of Death (m/d/y) | $ | $ |
| ☐ Dismemberment | Date of Loss (m/d/y) | $ | $ |
| ☐ Waiver of Premium | Date of Disability (m/d/y) | $ | $ |
| ☐ Accelerated Benefits | Date of Disability (m/d/y) (if applicable) | $ | $ |

## 5. Employee Eligibility

| Date Hired (m/d/y) | Date Insurance Effective (m/d/y) | Occupation | Scheduled Hours |
|---|---|---|---|
| Date Premiums Terminated (m/d/y) (if applicable) | | Class (as defined by Policy) | |
| Last Day at Work | Reason<br>☐ Death ☐ Illness ☐ Layoff ☐ Leave of Absence ☐ Retired | | |

**Salary Information (as of date last worked)**

| ☐ Hourly<br>Rate per Hour $ | ☐ Salary<br>Rate per Year $ |
|---|---|
| ☐ Other (i.e.: commissions, bonus, overtime or other compensation) | Date of Last Pay Increase (m/d/y) |

I certify that the above statements are true and correct.

| Signature of Plan Administrator/Contact<br>X | Date (m/d/y) |
|---|---|

# Sun Life Assurance Company of Canada

## Group Life Claim
## Section B: Death Benefit Claimant's Statement

Sun Life Financial

### Instructions

Please provide a certified copy of the Official Death Certificate to the employer with this form.

Return to:
Sun Life Assurance Company of Canada
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

Complete this form if benefits are legally payable to you as a beneficiary. You are a beneficiary if the insured designated you on his or her most recently dated enrollment or beneficiary designation form. When there is more than one beneficiary, each beneficiary must complete a separate form.

Please see the next page for additional instructions if:

- The beneficiary is the estate of the insured
- The beneficiary is a trust
- The beneficiary is a minor
- The insured's death has been ruled accidental

### 1. Information About the Insured

Please PRINT clearly.

| Deceased's Name (first, middle initial, last) | Social Security Number | Group Policy Number |
|---|---|---|
| | | |

### 2. Information About the Beneficiary

For individuals, your TIN is your Social Security Number or your IRS Individual Taxpayer Indentification Number. For other entities, it is your Employer Identification Number.

| Name of Beneficiary (first, middle initial, last) | Date of Birth (m/d/y) |
|---|---|
| Social Security Number or Tax Identification Number | |
| Address of Beneficiary (include city, state and zip code) | Telephone Number |

### 3. Certifications and Signature

The IRS does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Cross out item 2 if the IRS has notified you that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Under penalties of perjury, I certify that

1. the Tax Identification Number shown above is correct; and
2. I am not subject to backup withholding because
   a. the IRS has not notified me that I am subject to backup withholding as a result of my failure to report all interest or dividends, or
   b. the IRS has notified me that I am no longer subject to backup withholding.

I certify that the above statements are true and complete.

| Signature<br>X | Date (m/d/y) |
|---|---|
| | |

### 4. Method of Payment

If your claim is approved and your share of proceeds exceeds $10,000, we will open a Sun Financial Benefit Account in your name. The Benefit Account is an interest-bearing checking account that gives you immediate access to your Group Life benefits. You simply write a check for all, or a portion, of the proceeds.

*Continued on next page*

## 4. Method of Payment Cont'd

The Benefit Account is free and is guaranteed by Sun Life Assurance Company of Canada. Funds kept in your Benefit Account earn interest. For the current interest rate, call toll-free, 1-800-225-3950, extension 6930. In Massachusetts, call 1-800-342-3936, extension 6930. Please note: We will use your signature on the previous page to verify your signature on any checks that you write.

Beneficiaries can elect to receive the proceeds through the Sun Financial Benefit Account or in a lump sum check. Please indicate your choice below:

☐ I elect the Sun Financial Benefit Account.
☐ I elect a lump sum payment.

## 5. Additional Instructions

### If the Beneficiary is the Estate

**In some cases, life insurance may be payable to the insured's estate. The employer's Group Policy specifies the situations under which benefits are payable to the estate.**

Payment of the life insurance benefits in these cases will be made to the executor or administrator of the estate. The executor or administrator is appointed by a probate court and is responsible for managing the insured's estate. Please note that a person named as the executor or administrator in the insured's last will & testament **must be** appointed by the court before payment can be made.

The executor or administrator of the estate should complete the Claimant's Statement and provide a certified copy of the **Letters Testamentary** or **Letters of Administration** issued by the probate court. The estate tax identification number (not the Social Security number) is required on the Claimant's Statement.

### If the Beneficiary is a Minor

If the beneficiary is a minor and does not have a guardian, we can generally pay a life insurance benefit up to $50,000 to the minor under the state's Uniform Transfers to Minors Act (UTMA). To do so, an adult member of the minor's family needs to establish an account at a bank, trust company, savings institution or credit union in the adult's name as custodian for the minor beneficiary under the UTMA.

Once the account has been established, the custodian must provide Sun Life Assurance Company of Canada with written confirmation of the bank's name, address and routing number along with the account name and account number. The custodian also must complete and sign the Claimant's Statement (Section B, Part 2 of this packet). Enter the custodian's name and minor's name. For example: "Martha Doe, on behalf of Mary Doe." Then provide the minor's Social Security Number and date of birth. We can then wire transfer the funds directly to the account or issue a check to the custodian on behalf of the minor.

Alternatively, we can pay the life insurance benefit to the court appointed guardian of the minor's estate. To do so, the guardian must provide us with a certified copy of the court document appointing the guardian of the minor's estate. The guardian must complete and sign the Claimant's Statement as guardian. Enter the minor's Social Security Number and date of birth on the Claimant's Statement.

### If the Beneficiary is a Trust

After Sun Life Assurance Company of Canada receives notice that the beneficiary of a policy is a Trust, we will prepare and send a **Verification of Trust** form to be completed by the Trustee and returned for file.

The trustee should complete the Claimant's Statement. The trust's Tax Identification Number, (not the Social Security number), is required on the Claimant's Statement.

### If the Insured Died Accidentally

When the insured's death is the result of an accident, accidental death benefits may be payable if

- The Group Policy and employee class contain accidental death benefits
- The cause of death is "accidental" as defined under the Group Policy
- The Policy exclusions do not apply (please refer to the Group Policy)

The official police or fire department report of the accident must be furnished to determine if accidental benefits are payable. If a toxicology test is administered, the official results of the test must be provided. We may need other information or reports to determine if the death is accidental under the terms of the Policy.

# Sun Life Assurance Company of Canada

## Group Life Claim

## Section C: Disability, Dismemberment or Accelerated Benefits – Employee's Statement

Sun Life Financial™

### 1. Information About You

Please PRINT clearly.

Return to:
Sun Life Assurance Company of Canada
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

| Employee's Name (first, middle initial, last) ☐ Male ☐ Female | Social Security Number | Date of Birth (m/d/y) |
|---|---|---|
| Address (street, city, state, zip code) | | Telephone Number |
| ☐ Single ☐ Widowed ☐ Married ☐ Divorced | Occupation | Employer's Name and Policy Number |

### 2. Information About the Disability, Dismemberment or Accelerated Benefits

If you need more space, attach additional pages.

| |
|---|
| A. Date of Accident or Date You First Noticed Symptoms of Your Illness (m/d/y) |
| B. Describe in detail how, when and where the accident occurred or describe the nature of your illness and its first symptoms |
| C. **For Dismemberment Only.** Please state the date and nature of your loss |
| D. **For Accelerated Benefits Only.** Write in the amount you are requesting* |

| E. Last Day You Worked Prior to the Disability (m/d/y) | F. Date You Were First Unable to Work (m/d/y) |
|---|---|

| |
|---|
| G. Have you returned to work? ☐ Yes ☐ No If yes, give date |
| H. Please explain in your own words what is preventing you from resuming employment |

* For most contracts the limit is 75% of the face amount for Group Life Insurance.

Complete E, F, G, and H if applicable.

### 3. Information About Physicians and Hospitals

A. Please provide the names and addresses of all physicians you have seen for this condition.

| Name | Telephone Number |
|---|---|
| Address | |
| Specialty | Date of Treatment (m/d/y) |

| Name | Telephone Number |
|---|---|
| Address | |
| Specialty | Date of Treatment (m/d/y) |

## 3. Information About Physicians and Hospitals (continued)

**B.** If you have been hospital-confined for this condition, please provide names and addresses of hospitals and confinement dates.

If you need more space, attach additional pages.

| Name of Hospital(s) | Address | Dates of Confinement |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 4. Information About Your Training, Education and Experience

Complete this section if the claim is for Waiver of Premium.

**A.** What is your level of education?

☐ Grade School ☐ Trade School ☐ High School ☐ College
☐ Other Course (please specify below)

**B.** Please list all previous occupations and the dates worked for each employer.

Please attach a copy of your resume, if available.

| Employer's Name | Dates of Employment | Occupation/Type of Work |
|---|---|---|
| | | |
| | | |
| | | |

## 5. Authorization

**I understand** that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

**I certify** that the above statements are true and complete and I authorize physicians, hospitals, the Social Security Administration, and my employer to release information to Sun Life Assurance Company of Canada with respect to this claim.

| Employee's Signature<br>X | Date (m/d/y) |
|---|---|

# Sun Life Assurance Company of Canada
## Group Life Claim
## Section D: Authorization

Sun Life Financial

### 1. Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care 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; or the Medical Information Bureau, Inc., to disclose my entire medical record and any other protected health information concerning me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affilitates, 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 and 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 entity named above 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 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.

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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, 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 Authorized Representative | Group Policy Number |
|---|---|
| Signature of Employee or Authorized Representative<br>X | Date (m/d/y) |

## 2. Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

**I HEREBY AUTHORIZE** any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, therapist or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) insurance company; and (c) insurance support organization to disclose any psychotherapy notes relating to me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affilitates, 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 entity named above 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 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 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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, 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 Authorized Representative | Group Policy Number |
|---|---|
| Signature of Employee or Authorized Representative<br>X | Date (m/d/y) |

## 3. 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 and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

**I HEREBY AUTHORIZE** any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care 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, affilitates, 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.

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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, 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 Authorized Representative | Group Policy Number |
|---|---|
| Signature of Employee or Authorized Representative<br>X | Date (m/d/y) |

# Sun Life Assurance Company of Canada

## Group Life Claim

## Section E: Attending Physician Statement

Sun Life Financial

### 1. Patient Information

To be completed by the Physician and returned.
Please PRINT clearly.

Return to:
Sun Life Assurance Company of Canada
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

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

| Name of Patient (first, middle initial, last) | Social Security Number | Date of Birth (m/d/y) | |
|---|---|---|---|
| Street Address | City | State | Zip Code |
| Employer Name | | Group Policy Number | |

### 2. History

| A. When did symptoms first appear or accident happen? | B. Date Disability Commenced (m/d/y) |
|---|---|
| C. Patient's Height | Patient's Weight |
| D. Names and Addresses of Other Treating Physicians (if applicable) | |

### 3. Diagnosis

Include ICD9 Code.

* Include current X-Rays, EKGs, MRIs, laboratory data and any other clinical findings.

| A. Diagnosis (including any complications) |
|---|
| B. **For Accelerated Benefits Only**<br>If the patient has a terminal illness, please indicate the life expectancy: months |
| C. Objective Findings* |
| D. Subjective Symptoms |

### 4. Treatment for this Condition

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

| A. Date of First Visit (m/d/y) | B. Date of Last Visit (m/d/y) | C. Date of Last Examination (m/d/y) |
|---|---|---|
| D. Frequency of Treatment<br>☐ Weekly ☐ Monthly ☐ Other If Other, specify frequency | | |
| Nature of Treatment | | |

### 5. Progress

| A. Has Patient ☐ Recovered ☐ Not Changed ☐ Improved ☐ Retrogressed | B. Is Patient ☐ Ambulatory ☐ Bed confined | |
|---|---|---|
| C. If not changed or retrogressed, please explain | | |
| D. Has patient been hospital confined? ☐ Yes ☐ No | From | Through |
| E. If yes, give name and address of hospital | | |

## 6. Limitations

**A.** In a normal day, the patient may:

| | | | | | |
|---|---|---|---|---|---|
| **1.** Stand/Walk | ☐ None | ☐ 1 - 4 hours | ☐ 4 - 6 hours | ☐ 6 - 10 hours | |
| **2.** Sit | ☐ 1 - 3 hours | ☐ 3 - 5 hours | ☐ 5 - 10 hours | | |
| **3.** Drive | ☐ 1 - 3 hours | ☐ 3 - 5 hours | ☐ 5 - 10 hours | | |

**B.** 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 |

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

**D.** During the day, is the patient able to:

| | 67 - 100% | 34 - 66% | 1 - 33% | 0% |
|---|---|---|---|---|
| **1.** Bend | ☐ | ☐ | ☐ | ☐ |
| **2.** Squat | ☐ | ☐ | ☐ | ☐ |
| **3.** Climb | ☐ | ☐ | ☐ | ☐ |
| **4.** Twist Body | ☐ | ☐ | ☐ | ☐ |
| **5.** Push | ☐ | ☐ | ☐ | ☐ |
| **6.** Pull | ☐ | ☐ | ☐ | ☐ |
| **7.** Balance | ☐ | ☐ | ☐ | ☐ |
| **8.** Kneel | ☐ | ☐ | ☐ | ☐ |
| **9.** Crawl | ☐ | ☐ | ☐ | ☐ |
| **10.** Grasp | ☐ | ☐ | ☐ | ☐ |
| **11.** Reach | ☐ | ☐ | ☐ | ☐ |

**E.** Maximum lifting is _____ pounds

**F.** Can the employee work an 8 hr. day with the above restrictions? ..... ☐ Yes ☐ No

If not, how many hours could they work with the above restrictions? _____

## 7. Physical Impairment

☐ Class 1 No limitation of functional capacity; capable of heavy work* ..... No Restrictions (0 - 10%)

☐ Class 2 Medium manual activity* ..... (15 - 30%)

☐ Class 3 Slight limitation of functional capacity; capable of light work* ..... (35 - 55%)

☐ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity ..... (60 - 70%)

☐ Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity ..... (75 - 100%)

* As defined in federal dictionary of occupation titles

## 8. Cardiac (if applicable)

**A.** Functional Capacity (American Heart Association)

☐ Class 1 (no limitation)
☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)
☐ Class 4 (complete limitation)

**B.** Therapeutic Class (activity)

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

**C.** Blood Pressure - Last Visit _____

## 9. Mental Impairment (if applicable)

- ☐ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitation)
- ☐ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
- ☐ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
- ☐ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
- ☐ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustments (severe limitation)

**A.** Do you believe this patient is competent to endorse checks and direct the use of proceeds thereof? ..... ☐ Yes ☐ No

**B.** What is the patient's current DSM-IV-R diagnosis?

| |
|---|
| Axis I: |
| Axis II: |
| Axis III: |
| Axis IV: |
| Axis V: |

## 10.Work Capabilities

**A.** Is patient capable of working within these limitations? ..... ☐ Full time ☐ Part time

**B.** Is patient capable of another occupation on a full-time basis? ..... ☐ Yes ☐ No
On a part-time basis? ..... ☐ Yes ☐ No

## 11.Remarks

## 12.Physician Information

| Name of Attending Physician | Degree/Specialty | Telephone | |
|---|---|---|---|
| Street Address | City | State | Zip Code |

I understand that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

| Attending Physician's Signature*<br>X | Date (m/d/y) |
|---|---|

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