CANADA POSTES POST CANADA

From anywhere... to anyone

Employee's Medical Information and Attending Physician's Statement

Claim for Disability Insurance Policy No. 50800

Sun Life Financial

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

To the Attending Physician:
Please fill out this form completely and as soon as possible to ensure that there is no delay of any payments to the employee. Sun Life Assurance Company of Canada will use the information on this form to determine the employee's eligibility for disability benefits. Your accurate and detailed completion of this form will help us to arrive at a just decision. **The employee must complete and sign Part 1 of the form before you complete Part 2.** The employee is responsible for the cost of completing this form. If the employee's claim is approved, Sun Life Financial and Canada Post Corporation will jointly review the employee's progress and potential to return to work. From time to time, Sun Life Financial may request up-to-date medical or fitness information from you to support these reviews.

Part 1: Employee information (The employee must complete Part 1 of the form before the physician completes Part 2)

1 Employee Information

Last Name		Given Name	Maiden Name (for Quebec residents)
Address (street number and name, apartment or suite)			Home Telephone No. ( )
City		Province	Postal Code
Date of Birth (d/m/y)	Sex ☐ Male ☐ Female	Employee Identification No.	Social Insurance Number (for tax purposes)

2 About your illness or injury

Attach extra sheets, if necessary.

1. Please describe your present illness or injury and how it prevents you from working. Include a description of which duties of your job you are *unable* to perform because of your illness or injury. As well, list the duties of your job you *are* able to perform.

2. When did your symptoms first appear? Date (d/m/y)

3. Have you ever had the same or similar illness or injury? No ☐ Yes ☐▶ Please explain and give dates

4. On what date did you first see a doctor for this illness or injury? Date (d/m/y)

5. Is your illness or injury work related? No ☐ Yes ☐▶ If yes, please explain

6. Did the doctor recommend a change in your daily habits or restrictions on the type of work you could do?
No ☐ Yes ☐▶ If yes, please describe the change and the date the recommendation was made.

2 About your Illness or injury (continued)

7. What treatment are you presently receiving (medicine, diets, advice from a doctor, physiotherapy, etc.)?

8. Do you have an active, valid driver's licence? No ☐ Yes ☐ If yes, please specify class

If your driving has been restricted as a result of your illness or injury, please give details.

9. 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 (d/m/y)

3 Your general medical history

Attach extra sheets if necessary.

1. List all of the doctors you have seen during the past five years for any other illness or injury.

Doctor	Address	Nature of Illness	Dates of Visit (d/m/y)

2. Please list names and addresses of all hospitals where you have been treated during the past five years, including any type of surgery.

Hospital	Address	Nature of Illness/Surgery	Dates of Stay (d/m/y)

4 Employee's authorization and signature

- I certify that the statements on this form are true and complete.
- I authorize the following to provide to Sun Life Financial the information needed to administer or pay my claim: my doctor; Canada Post Corporation; Workers' Compensation Board or Commission de la santé et de la sécurité au travail in the Province of Quebec; any person or organization who has relevant personal information about me including health professionals and institutions, investigation agencies, insurers and persons performing services for Sun Life Financial.
- I consent to a personal investigation.
- I agree that a photocopy of this authorization is as valid as the original.

Employee's Signature	Date (d/m/y)
X	

Part 2: Attending Physician's Statement

1 History

1. What was the date of the patient's first appointment for this illness or injury? Date (d/m/y)

2. What was the date of the patient's latest appointment? Date (d/m/y)

3. Did you recommend that the patient stop work? No ☐ Yes ☐ As of what date? Date (d/m/y)

4. How often are the patient's appointments? Weekly ☐ Bi-weekly ☐ Monthly ☐
   Other ☐ Please specify:

5. Was the patient's illness or injury caused by an accident? No ☐ Yes ☐ If yes, give details and the date of the accident.

6. Describe the pertinent symptoms, their severity, their duration and their impact on the illness or injury (including the patient's ability to work).

7. When did the symptoms first appear? Date (d/m/y)

8. Has the patient ever had a similar or related condition? No ☐ Yes ☐ If yes, state when and describe the condition.

9. Is the condition due to injury or illness caused by employment? Unknown ☐ No ☐ Yes ☐ If yes, give details.

10. Is the condition due to or related to pregnancy? No ☐ Yes ☐ Give date of confinement.
    From Date (d/m/y) to Date (d/m/y)

11. How is the patient restricted or limited by the condition?

12. What is the patient's current status?
    Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined ☐

2 Clinical findings

Please describe the physical findings in relation to the illness or injury.

3 Diagnoses

What are the diagnoses that have led to the illness or injury? Please list in order of their importance to the patient's illness or injury and their impact on the claimant. If the condition is psychiatric, use DSM IV terminolgy.

4 Investigations

What procedures and examinations were done? Please include copies of the reports of X-rays, ECGs, laboratory data and all other investigations related to the illness or injury.

5 Treatment

1. Was the patient hospitalized? No ☐ Yes ☐▶ If yes, give dates.

   From Date (d/m/y) To Date (d/m/y)

2. Was surgery performed? No ☐ Yes ☐▶ If yes, give details

Date	Type of Surgery

3. What medications were given to the patient? Please include name, dosage and the dates of any medication changes.

4. Was counselling or psychotherapy given? No ☐ Yes ☐▶ If yes, give frequency and duration.

5. Was physiotherapy/chiropractic treatment given? No ☐ Yes ☐▶ If yes, give frequency and duration.

6. What other treatments were given?

5 Treatment (continued)

7. Please describe the results of the treatment plan.

8. How well has the patient been able to comply with the treatment plan?

9. Please give the names, specialties and appointment dates of any consulting physicians.

Name	Specialty	Appointment Date (d/m/y)

6 Cardiac

Complete if applicable.

1. What is the functional capacity (American Heart Association)? If class 3 or 4, please include a copy of stress test or cardiac echograms.

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

2. What is the latest blood pressure reading for the patient? ___/___

7 Return to work plan

1. Which of the following best describes the progress of the patient's condition since the patient stopped working?

   Recovered ☐
   Improved ☐
   Unchanged ☐
   Regressed ☐

2. Please describe any functional (physical or psychological) restrictions of the patient.

3. In what period can recovery of usual functional abilities be anticipated?

   1-3 months ☐
   4-6 months ☐
   7-9 months ☐
   over 9 months ☐

4. Have you scheduled a reassessment for this patient? No ☐ Yes ☐▶ If yes, give date. Date (d/m/y)

7 Return to work plan (continued)

5. Please describe any other factors that may affect this patient's ability to return to work.

6. In your opinion, how motivated is the patient to return to work?

Highly motivated ☐
Motivated ☐
Slightly motivated ☐
Not motivated ☐

8 Additional information

1. In your opinion, does the patient have any physical or mental limitations that would prevent the patient from handling his/her own financial affairs?

No ☐

Yes ☐ ▶ If yes, give details of any physical or mental limitations.

2. Would it be of assistance to speak to a Sun Life Assurance Company of Canada Medical Director? No ☐ Yes ☐

9 Physician information

Name		
Street Address		
City	Province	Postal Code
Specialty	Tel. No. ( )	Fax No. ( )

Signature	Date (d/m/y)
X	

To keep this document confidential, please send this form to the nearest Sun Life claims office listed below:

Halifax
Fax: 1 866 639-7850
1100-1809 Barrington St.
Halifax NS B3J 3K8

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

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