CANADA POSTES POST CANADA

From anywhere... to anyone

Employee'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.

IMPORTANT:

- Please complete this form and return it to your Employee Relations Representative. The address for your representative is included at the end of this form. Your Employee Relations Representative will send the form to Sun Life Assurance Company of Canada.
- You **must** notify Sun Life Financial promptly if:
  - your medical condition improves so that you are able to work,
  - you begin working either as a full-time or part-time employee or as a self-employed person, or
  - you change your address.
- Fraudulent claims are very costly for all participants in benefit plans. It is Sun Life Financial's practice to prosecute fraudulent claims.

1 About you

Last Name	Given Name	Maiden Name (for Quebec residents)
Address (street number and name, apartment or suite)		
City	Province	Postal Code
Home Telephone No. ( )	Date of Birth (d/m/y)	Employee Identification No.

How are you sending the Employee's medical Information and Attending Physician's Statement? (check one)

☐ I am sending the form to Sun Life Financial.

☐ My doctor is sending the form directly to Sun Life Financial.

2 About your employment

Team Leader	Telephone No. ( )
Work Location Postal Code	Shiftt
Work Location (City, Plant or Post Office)	

3 About your illness or injury

1. From what date did your illness or injury prevent you from working? Date (d/m/y)

2. Are you confined to your house? No ☐ Yes ☐ Are you confined to your bed? No ☐ Yes ☐

   Are you confined to hospital? No ☐ Yes ☐

3. Describe your daily activities.

4. Have your normal daily activities been limited in any way since your illness or injury began?
   No ☐ Yes ☐▶ If yes, please give details.

4 Illness or injury as a result of an accident

1. Is your illness or injury the result of an accident?
   No ☐▶ Continue with the next section **"Canada/Quebec Pension Plan benefits."**
   Yes ☐▶ Answer the following questions.

2. Where did the accident happen?
   At home ☐
   At work ☐
   Other ☐

3. When did the accident happen? Date (d/m/y)

4. How did the accident happen?

5. If it was a motor vehicle accident, were you the driver? No ☐ Yes ☐

6. If your illness or injury is the result of an accident, are you taking legal action against any other person or organization?

   Yes ☐▶

Name of Lawyer		
Address		Telephone ( )
City	Province	Postal Code

   No ☐▶ Please explain why you are not taking legal action.

5 Canada/Quebec Pension Plan benefits

1. Have you applied for a Disability Pension under the Canada/Quebec Pension Plan?

   Yes ☐▶ When did you apply? Date (d/m/y)

   No ☐▶ Give reasons why you have not applied.

2. If you have applied for a Disability Pension, has your application been approved?

   Yes ☐▶ Please include a copy of the Notice of Entitlement with this form.

   No ☐▶ If you have been denied or you are appealing a decision, please explain and give dates.

6 Your other income

Please list any amounts of money you are currently receiving or expect to receive each month from the following sources. We may take some of these amounts into consideration when we calculate your Long-Term Disability benefit.

Source	Name of source & Policy Number	Have you applied for this income? Yes	No	Are you receiving or do you expect to receive this income? Current	Expected	Amount per MONTH
Other Group/Association Plans		☐	☐	☐	☐	
Other Government Plans		☐	☐	☐	☐	
Auto insurance		☐	☐	☐	☐	
Canada Post Pension Plan		☐	☐	☐	☐	
Criminal Victims Benefit		☐	☐	☐	☐	
Other (please give details)		☐	☐	☐	☐	

7 Workers' Compensation benefits

1. Are you receiving, or do you expect to receive, Workers' Compensation benefits? No ☐ Yes ☐▶ Please continue.

   What is the claim number ☐ How much is the benefit per week? $ ☐

2. Have you attached a copy of a decision letter from Workers' Compensation Board (WCB) or CSST, if applicable?

   No ☐▶ If no, is WCB's or CSST's decision pending? No ☐ Yes ☐

   Yes ☐

3. Have you received a permanent disability award?

   No ☐▶

   Yes ☐▶ When was the permanent disability award approved? Date (d/m/y) ☐

   What was the effective date of the permanent disability award? Date (d/m/y) ☐

   Was (or is) it a monthly benefit? No ☐ Yes ☐▶ What was (or is) the amount? $ ☐

   Was it a lump sum settlement? No ☐ Yes ☐▶ What was the amount? $ ☐

4. If your claim has been denied or terminated, have you appealed the decision?

   Yes ☐▶ If yes, when did you appeal it? Date (d/m/y) ☐

   No ☐▶ If no, please explain why.

   ☐

   What level of appeal was it (if known)?

   Please describe.

8 Your education and acquired skills

1. What is the highest grade level you completed or the highest degree you obtained?

2. Please describe other educational training or skills upgrading (include on-the-job training, special interest courses, etc.). In addition, list any other skills you have acquired. These skills may include typing, computer skills, operation of equipment, supervisory skills, special licenses, etc. They may also include skills acquired through volunteer work, hobbies and interests. Please use extra sheets if necessary.

9 Your work history

Attach a resume if available.

From	To	Employer	Job Title and Duties

10 Returning to work

1. When do you expect to be able to return to your own job? Date (d/m/y)
2. When do you expect to be able to return to do any other job? Date (d/m/y)
3. Have you tried to return to work already?
   No ☐
   Yes ☐▶ Please answer the following questions

   What were the dates that you returned to work?

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

   If your return to work was not successful, please explain why.

11 Automatic deposit of your monthly benefit payments

For your convenience, your Disability Insurance payments will be deposited directly into your account at any bank, trust company, Caisse populaire or credit union in Canada. If you want payments deposited into a chequing account, please attach a voded cheque from that account. If you want payments deposited into a savings account, please provide details.

Bank Name		
Address		
Bank Number ☐☐☐	Branch/Transit Number ☐☐☐☐☐	Account Number ☐☐☐☐☐☐☐

12 Your declaration and authorization

Fraudulent claims are costly for all participants in benefit plans. As Administrator of this plan, we may verify the accuracy of the information given in support of your claim.

If you are age 60 or over, please attach a copy of your birth certificate, baptismal record, passport or drivers license as proof of age.

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

- I certify that the statements on this form are true and complete.
- I understand that Sun Life Assurance Company of Canada may investigate this claim. I authorize Sun Life Assurance Company of Canada, it's agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I agree that Sun Life Assurance Company of Canada and my Plan Sponsor may share financial information related to my claim for purposes relevant to the management of the Plan. I understand that the information about me pertaining to this claim may be reviewed in the event this Plan is audited.
- I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my claim.
- I authorize Sun Life Assurance Company of Canada and my Plan Sponsor and their medical consultants to exchange information about me, except for details relating to diagnosis, treatment or medication, that is relevant to this claim for the purpose of planning and managing my rehabilitation and return to work.
- I authorize Sun Life Assurance Company of Canada to provide to the Disability Management Provider for Canada Post copies of relevant correspondence relating to this claim for the purpose of monitoring the status and progress of this claim.
- I agree to notify Sun Life Assurance Company of Canada promptly if there is a change in my condition that affects my ability to return to work or a change in my monthly income.

Name (please print)	
Signature X	Date (d/m/y)

13 Authorization to exchange medical information

a) I hereby authorize the Disability Management ("DM") provider for Canada Post to provide to Sun Life Assurance Company of Canada a copy of all of my medical information including specific test results, diagnosis, treatment, narrative comments and independent medical examination report, which the DM provider for Canada Post has in its possession in connection with my claim under the short-term disability program for the purpose of assisting in the transition and subsequent adjudication of any claim I may make under the Long Term Disability Insurance Plan.

Name (please print)	
Signature X	Date (d/m/y)

To facilitate rehabilitation, the DM provider for Canada Post will request copies of relevant medical information related to my claim under the Long Term Disability Insurance Plan from SunLife Assurance Company of Canada. This information will be forwarded confidentially to the DM provider for Canada Post. It will be filed in my Employee Health Record and will only be available to the DM provider for Canada Post.

I understand that this is a voluntary authorization and that I do not have to sign it.

Name (please print)	
Signature X	Date (d/m/y)

After you have completed this form, please return it to your Employee Relations Representative at the following address: