Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Employer

Sun Life Financial®

Instructions for the Plan Administrator

Please call our Customer Service Center at 1-800-247-6875 from 8 a.m. to 8 p.m. Eastern Time to report any scheduled or actual return-to-work dates as soon as possible.

Please make sure that the employee initiates the Long Term Disability claim filing process as soon as it first appears that his or her disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

Please be sure to submit the Employer's Statement directly to Sun Life Financial.

The Employer must:

- ☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.
- ☐ Attach copies of employee's medical information relating to the disability (if available).
- ☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.
- ☐ Attach a copy of all payroll documentation and attendance records for the last six months.
- ☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

NOTE:

FOR TRANSITION CLAIMS: If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes on page 4. Then complete the rest of the Employer portion of this claim packet.

FOR NON-TRANSITION CLAIMS: Fill out the entire Employer portion of this packet.

Mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

Fraud Warnings

State law requires that we notify you of the following:

General fraud warning: 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 subjects such person to criminal and civil penalties.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, MA, MN, RI, TX, and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DE, ID, and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: 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 may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OH: 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 is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR and VA: 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 have violated state law.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Sun Life Assurance Company of Canada
Long Term Disability Claim Packet - Employer

Sun Life Financial®

Employer's Statement

1 General Information

Please print clearly.

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Return to:
Sun Life Assurance
Company of Canada
Group LTD Claims,
SC 4328
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Name of employer		Group policy number	Class
Street address	City	State	Zip
Name and address of division where employee works (if different from above)			

Does your company have a formal Return to Work Program? .... ☐ Yes ☐ No	
Contact Person	Telephone number

2 Employee Information

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Name of employee (first, middle initial, last)			☐ M ☐ F
Social Security number	Date of birth (m/d/y)	Telephone number	
Employee's street address	City	State	Zip Code

3 Employment and Claim Information

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Date hired (m/d/y)	Effective date of coverage	Date last worked (m/d/y)	Hours worked last day
What was the employee's permanent occupation on his/her last date of work?			
How long had employee been in occupation? Years: Months:		Regularly scheduled work week: Days per week: Hours per day:	
Has the employee's employment been terminated? ☐ Yes ☐ No		If yes, provide termination date	
Why did employee cease working?			
Is the condition due to an injury or sickness arising out of employee's job? ☐ Yes ☐ No ☐ Disputed			
Has a Workers' Compensation claim been filed?... ☐ Yes ☐ No If "yes," please include the initial report of illness/injury and award/denial notice with this claim.			
Name and address of your Workers' Compensation carrier:			Telephone number
Was employee covered under prior LTD policy?.............. ☐ Yes ☐ No	Effective date under prior policy (m/d/y)		Termination date under prior policy (m/d/y)
Has employee returned to work? ☐ Yes ☐ No If yes: ☐ With restrictions ☐ Full capacity			Date returned (m/d/y)

Claimant: DOB: Policy no.: CC no:

4 Salary and Benefits Information – Complete this section for **all** claimants.

Please note that additional financial information may be required depending on your specific policy.

Please provide 6 months of payroll records prior to date last worked. Be sure to include documentation of hours worked, payments, contributions to LTD, and attendance records.

How was the employee paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per week:

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

Enrollment form is required if coverage is contributory.

Does employee contribute toward the LTD premium?.............................. ☐ Yes ☐ No

- If "yes," attach a copy of employee's enrollment form to this claim and indicate percentage contribution.................................

Employee:	Employer:
%	%

- Are employee contributions made with pre-tax dollars?......................... ☐ Yes ☐ No

5 Other Income Information – Complete this section for **all** claimants.

Check all that apply and provide details for each source of income.

Is employee currently receiving, or entitled to receive, benefits from any of the following sources?

Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐ Sick Pay	$	☐ Wkly ☐ Mthly	
☐ Salary Continuance	$	☐ Wkly ☐ Mthly	
☐ State Disability	$	☐ Wkly ☐ Mthly	
☐ Workers' Compensation	$	☐ Wkly ☐ Mthly	
☐ Unemployment Compensation	$	☐ Wkly ☐ Mthly	
☐ Social Security Disability/Retirement	$	☐ Wkly ☐ Mthly	
☐ Disability/Retirement Pension	$	☐ Wkly ☐ Mthly	
☐ Automobile No-fault Insurance	$	☐ Wkly ☐ Mthly	
☐ Union Disability	$	☐ Wkly ☐ Mthly	
☐ Severance	$	☐ Wkly ☐ Mthly	
☐ Other:	$	☐ Wkly ☐ Mthly	

6 Employee's Occupation Information – Complete this section for **all** claimants.

Required: Please submit a copy of the employee's formal job description.

Job title / Major job duties (attach employee's formal job description)

7 Physical Aspects of Occupation – Complete this section for **all** claimants.

Please note that additional occupational information may be required.

In a typical work day, give the number of hours the employee spends in each of these positions and if employee may alternate positions.

		May Alternate Positions			
Position	**Total Number of Hours**	**At Will**	**15-30 Mins.**	**Hourly**	**Never**
Sitting		☐	☐	☐	☐
Standing		☐	☐	☐	☐
Walking		☐	☐	☐	☐
Driving		☐	☐	☐	☐

Continued on next page

7 Physical Aspects of Occupation continued – Complete this section for **all** claimants.

In a typical work day, the employee must:

	Occasionally (1/4 – 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)	Never
Bend/Stoop	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Crawl/Crouch	☐	☐	☐	☐
Lift ______ lbs.	☐	☐	☐	☐
Carry ______ lbs.	☐	☐	☐	☐

Does the employee use feet for repetitive movements, as in operating foot controls?
Right foot ☐ Yes ☐ No   Left foot ☐ Yes ☐ No   Both feet ☐ Yes ☐ No

What are the major tasks requiring use of one or both hands?

Check all that apply.

Which of the following describes the employee's working environment?
- ☐ Working at heights
- ☐ Operating heavy machinery
- ☐ Precise manual dexterity
- ☐ Exposure to dust, fumes and gases
- ☐ Changes in temperature or humidity
- ☐ Other hazards (specify): ________________________

8 Non-Physical Aspects of Occupation – Complete this section for **all** claimants.

Does employee have to answer customer complaints? .... ☐ Yes ☐ No
Is employee primarily evaluated on production? .... ☐ Yes ☐ No
Is employee routinely subject to close supervision? .... ☐ Yes ☐ No
Does employee work closely with his/her co-workers? .... ☐ Yes ☐ No
Is employee responsible for the overall performance of his/her particular department? .... ☐ Yes ☐ No
Number of people this employee supervises __________

9 Checklist of Required Attachments – Complete this section for **all** claimants.

Failure to provide the following information could result in a delay of the initial benefit payment.

- ☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.
- ☐ Attach copies of employee's medical information relating to the disability (if available).
- ☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.
- ☐ Attach a copy of all payroll documentation and attendance records for the last six months.
- ☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

10 Certification and Signature – Complete this section for **all** claimants.

Tip: To certify eligibility, mail or fax the employee's enrollment form with the claim.

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Name of person completing this form	Telephone number: Fax Number:
Title	E-mail address: Company's Website:
Signature X	Date signed

For more information about Long Term Disability, the claim process and the status of your employees' claims, log onto your plan administrator web portal.