

EMPLOYEE'S SHORT TERM DISABILITY CLAIM REPORT

Must Be Completed in Full at No Expense to Sun Life and Health Insurance Company (U.S.)

Employer's Statement

Name of Employee (Last, First, M.I.)		Social Security Number	Group Policy Number
Employment Effective Date	Employee's Insurance Effective Date	Date Last Actively Worked	Reason For Leaving Work
Occupation	<input type="checkbox"/> Union Employee <input type="checkbox"/> Paid Hourly / Rate _____ <input type="checkbox"/> Non-Union Employee <input type="checkbox"/> Paid Salary	Basic Weekly Hours Worked	Days Worked - Please Check <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat
Basic Weekly Earnings	Date Of Last Salary Change	Insurance Class	This Employee Is Eligible For Salary Continuation Amount _____ Duration _____

Is employee's disability due to injury or sickness caused by insured's current or prior employment? Yes No

If "yes" and the Workers' Compensation carrier has denied, please provide us with a copy of the denial letter.

Has employee returned to work? Yes No (If "yes", give date returned) Full-time _____ Part-time _____

Does employee contribute towards the cost of this insurance? Yes No If yes, _____% paid by employee.

If the previous question is left blank, we will assume the employer pays 100%. Employee contributions were made on: Pre-tax Basis Post-tax Basis

Name of Employer	Telephone Number ()
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Employer's Address (No., Street, City, State, ZIP Code)

Signature of Administrator	Title	Date Signed
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Employee's Statement

Name Of Employee (Last, First, M.I.) - Please Print	Telephone Number ()	Social Security Number - -
Employee's Address (No., Street, City, State, ZIP Code)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Date Of Birth / /	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date You Last Worked Prior To Disability	Date Returned To Work (with any employer)	Spouse's Date Of Birth / /
		Were You Hospital Confined? (If "yes", give dates) <input type="checkbox"/> Yes <input type="checkbox"/> No From / / To / /

If disability is due to an accident or injury, please explain how, when and where it occurred.

Do you believe this disability was caused by your current or prior occupation or employment? Yes No

If related to prior or other employment. Please indicate name of employer: _____

Are you now receiving or have you applied for workers' compensation benefits? Yes No If yes, amount \$ _____

Are you entitled to, filed for, or receiving social security disability, social security retirement or any alternate benefit such as railroad retirement, state or county retirement, or state cash sickness benefits? Yes No If "receiving", indicate amount \$ _____ and attach award letter

Signature of Employee - I certify that the foregoing statements are true to the best of my knowledge.	Date Signed
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I authorize the release and disclosure of my protected health information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider to disclose or furnish to **Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.))** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect a claim; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature	Date Signed
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WARNING
STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT: 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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN FLORIDA: "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."

IN LOUISIANA: "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."

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

IN NEW YORK: "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 shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

IN PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (\$5,000) dollars nor more than ten thousand (\$10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Attending Physician's Statement

Name of Patient (Last, First, M.I.) - Please Print	Date of Birth / /
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Diagnosis	ICD - 9 Code
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Symptoms

Date of First Treatment for this Disability	Date of Most Recent Treatment	Frequency of Treatment Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Date of Next Appointment
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Disability Is Due To
 Sickness Accident/Injury If accident, explain how, when & where it occurred.

Is the disability due to injury or sickness caused by patient's current or prior employment? Yes No

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

If disability is due to pregnancy, please provide the following
 L.M.P.: _____ Expected Date of Delivery _____ Actual Date of Delivery _____ Type: Normal C-Section

Name of Surgical or Obstetrical Procedure (Describe fully, and provide dates if any)

If any of the following questions are answered "Yes"; then please provide the information to the right of that question.

Was the patient treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated in Emergency Room / /	Hospital	Physician
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Was the patient treated by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated By Another Physician	Physician
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Was the patient hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates Confined in Hospital From / / To / /	Hospital
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Did patient have outpatient surgery in a hospital or ambulatory surgical center? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery / /	Name of Facility
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Physical Impairment	<input type="checkbox"/> Class 1 - No Limitation of functional capacity, capable of heavy work. No restrictions. <input type="checkbox"/> Class 2 - Medium manual activity. <input type="checkbox"/> Class 3 - Slight limitation of functional capacity, capable of light work.	<input type="checkbox"/> Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity. <input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimum (sedentary) activity.
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Functional Limitations - Abilities

<p>Indicate frequency per day the listed activity can be performed. (N - Never, O - Occasional, F - Frequent, C - Constant)</p> <table style="width:100%"> <tr> <td style="width:50%;">LIFTING</td> <td style="width:50%;">CARRYING</td> </tr> <tr> <td>_____ 1-5 lbs.</td> <td>_____ 1-5 lbs.</td> </tr> <tr> <td>_____ 6-10 lbs.</td> <td>_____ 6-10 lbs.</td> </tr> <tr> <td>_____ 11-25 lbs.</td> <td>_____ 11-25 lbs.</td> </tr> <tr> <td>_____ 26-50 lbs.</td> <td>_____ 26-50 lbs.</td> </tr> <tr> <td>_____ 51-100 lbs.</td> <td>_____ 51-100 lbs.</td> </tr> <tr> <td>_____ Over 100 lbs.</td> <td>_____ Over 100 lbs.</td> </tr> </table>	LIFTING	CARRYING	_____ 1-5 lbs.	_____ 1-5 lbs.	_____ 6-10 lbs.	_____ 6-10 lbs.	_____ 11-25 lbs.	_____ 11-25 lbs.	_____ 26-50 lbs.	_____ 26-50 lbs.	_____ 51-100 lbs.	_____ 51-100 lbs.	_____ Over 100 lbs.	_____ Over 100 lbs.	<p>Indicate longest single time duration each activity can be performed.</p> <table style="width:100%"> <tr> <td>_____ Sitting</td> <td>_____ Kneeling</td> <td>_____ R Finger Dexterity</td> </tr> <tr> <td>_____ Total time on feet</td> <td></td> <td>_____ L</td> </tr> <tr> <td>_____ Standing</td> <td>_____ Inside</td> <td>_____ R Below Shoulders</td> </tr> <tr> <td>_____ Walking</td> <td></td> <td>_____ L</td> </tr> <tr> <td>_____ Bending</td> <td>_____ Outside</td> <td>_____ R Above Shoulders</td> </tr> <tr> <td>_____ Squatting</td> <td>_____ Working with</td> <td>_____ L</td> </tr> <tr> <td></td> <td>Others</td> <td rowspan="2" style="font-size: 3em; vertical-align: middle;">} Reaching</td> </tr> <tr> <td>_____ Stopping</td> <td>_____ Other (explain) _____</td> </tr> </table>	_____ Sitting	_____ Kneeling	_____ R Finger Dexterity	_____ Total time on feet		_____ L	_____ Standing	_____ Inside	_____ R Below Shoulders	_____ Walking		_____ L	_____ Bending	_____ Outside	_____ R Above Shoulders	_____ Squatting	_____ Working with	_____ L		Others	} Reaching	_____ Stopping	_____ Other (explain) _____
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Cardiac	Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 - No Limitation <input type="checkbox"/> Class 2 - Slight limitation <input type="checkbox"/> Class 3 - Marked limitation <input type="checkbox"/> Class 4 - Complete limitation
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Psychiatric Impairment (if applicable)	<input type="checkbox"/> Class 1 - (no limitations) <input type="checkbox"/> Class 2 - (slight limitations) <input type="checkbox"/> Class 3 - (moderate limitations) <input type="checkbox"/> Class 4 - (marked limitations) <input type="checkbox"/> Class 5 - (severe limitations)
	Please advise Multiaxial assessment on AXIS I _____ AXIS II _____ AXIS III _____ AXIS IV _____ Recent GAF _____

The patient has been continuously disabled (unable to work) from _____ to _____

The patient should be able to work full-time (date) _____ part-time on (date) _____ **Work Accommodations necessary**

Remarks

Name of Attending Physician - Please Print	Tax Identification Number
Address (No. Street, City, State, ZIP Code)	Telephone Number ()
Signature of Attending Physician	Date Signed
	Fax Number ()