

Short-Term Disability *SunAdvantage* Plan Sponsor Package

How to use this package:

REVIEW	<ul style="list-style-type: none">The links below will take you to the Plan Sponsor's Statement and Disability Job Demands Questionnaire included in this package. The "Return to Introductory Page" link on each document will take you back to this page.
COMPLETE	<ul style="list-style-type: none">You are able to save information typed into the forms.Complete the Plan Sponsor's Statement in its' entirety.Complete the Job Demands Questionnaire if the plan member is expected to be absent for 4 weeks or more.
SUBMIT	<ul style="list-style-type: none">Print the completed Plan Sponsor's Statement (pages 2 - 4) and Job Demands Questionnaire (pages 5 - 7, if submitting) and sign the Declarations at the end of the forms.Fax the forms to the Sun Life Group Disability Management office that manages your claims. You do not need to mail information that you fax. Please retain the original copy for your records.

[!\[\]\(666e09182d4cd268646ea700ea60dcdf_img.jpg\) Plan Sponsor's Statement for Short-Term Disability Benefits](#)

[!\[\]\(c3d993ca47bfe2a953c700506ce31fa0_img.jpg\) Disability Job Demands Questionnaire](#)

Plan Sponsor's Statement Claim for Short-Term Disability benefits *SunAdvantage*



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

1 Plan Member information

Sun Life Assurance Company of Canada must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety in order to avoid delays.

First name	Last name (Quebec residents – maiden name)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy) — —
Address (street number and name)			Apartment or suite
City		Province	Postal code
Home telephone number — —		Alternate telephone number — —	
Regular occupation title/Job name			

2 Plan Sponsor information

Please also submit the form, Disability Job Demands Questionnaire if the member is expected to be absent for 4 weeks or more.

Contract number	Sub./Class	Member ID	Division/Billing group number
Company name			
Address (street number and name)			
City		Province	Postal code
Contact person			
Contact's telephone number — —	Ext.	Email address	

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Date member started with the company (dd-mm-yyyy) — —	Last date of full-time duties/hours (dd-mm-yyyy) — —	Last date of modified work (if applicable) (dd-mm-yyyy) — —
Was the member's employment terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, on what date? <input type="text" value="Date (dd-mm-yyyy)"/>
To the best of your knowledge, why did the member stop working?		

5 Earnings and benefit information (continued)

5. Is the member entitled to any other benefits from any other source (e.g. WCB/WSIB/CSST/CPP/QPP)?

No Yes If *yes*, please describe.

From what date?

Date (dd-mm-yyyy)

— —

6. If the disability is due to pregnancy, has or will the member receive any maternity leave? No Yes

Date maternity leave begins

Date (dd-mm-yyyy)

— —

Date maternity leave ends

Date (dd-mm-yyyy)

— —

7. Are modified duties available? No Yes

Were modified duties offered? No Yes If *yes*, please describe duties (part-time/full-time/modified).

Did the member accept modified duties if offered? Yes No If *no*, please provide details below.

6 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First name	Position
Authorized signature X		Date (dd-mm-yyyy) — —
Telephone number — —	Fax number — —	

Visit our website:
[www.sunlife.ca/
health and work](http://www.sunlife.ca/health-and-work)

To ensure prompt submission, please fax this form, along with any other information in support of the plan member's claim, to the number that appears below for the Sun Life Assurance Company of Canada Group Disability Management Office that manages your claims. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

If you live in the Atlantic provinces, Quebec or Ottawa

For all other provinces or territories

Montreal:

Fax: 1-866-639-7846

PO Box 11037 Stn CV

Montreal QC H3C 4W8

Kitchener - Waterloo:

Fax: 1-866-209-7215

PO Box 100 Stn C

Kitchener ON N2G 3W9

Disability Job Demands Questionnaire

SunAdvantage



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

This form is to be completed by the Plan Sponsor and submitted with the Plan Sponsor's Statement if the plan member is expected to be absent for 4 weeks or more.

1 Plan member information

Contract number		Sub./Class	Member ID	Division/Billing group number
Last name (Quebec residents – maiden name)			First name	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)	Company name		
Regular occupation title/Job name				

2 Work environment and job activities

The remainder of this form asks for information on the plan member's specific job duties and should be completed by the plan member's immediate supervisor.

Attach extra sheets, if necessary.

If there is a prepared job description, please attach it to this form.

1. Does the plan member's job require work in any of the following conditions:

Outside	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %
In extremes of cold or heat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %
In a damp or humid environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %
In a noisy environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %
In a dusty or unventilated environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %
Around toxic fumes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, what percentage of time?	<input type="text"/> %

2. Does the plan member's job involve handling chemicals? No Yes
If yes, please list the chemicals below.

3. During the plan member's normal routine, what percentage of time does the job require the member to lift or carry the following weights?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
More than 50 lbs/22.7 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 20 lbs/9.1 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 10 lbs/4.5 kg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2 Work environment and job activities (continued)

4. During the plan member's normal routine, what percentage of time does the job involve the following activities?

	Never	1 to 25%	25 to 50%	50 to 75%	75 to 100%
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How much time is the plan member required to maintain the following activities before changing position or activity?

	0 to 30 minutes	30 to 60 minutes	60 to 90 minutes	More than 90 minutes
Sitting at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving at one time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the average day, what is the number of hours the plan member spends in the following positions or activities?

	0 to 2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Please list any machines, tools, or other equipment that the plan member uses on the job. You can either list the number of times per day the equipment is used or the percentage of time spent using the equipment, whichever is more applicable.

Type of equipment	No. of times per day OR Percentage of time

8. Cognitive/non-physical aspects of the job

- Does the plan member have to answer complaints? Yes No
- Is the plan member primarily evaluated on production? Yes No
- Does the plan member work closely with co-workers? Yes No
- Is the plan member responsible for the performance objectives/decision-making within his/her particular department? Yes No

Number of people this plan member supervises:

What percentage of the plan member's time is spent in the following activities?

Talking	Writing	Supervising other people
%	%	%

Please list any other relevant aspects of the job that may be considered stressful.

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3 Additional remarks

Please provide any additional information that may be relevant to this claim which has not been previously provided.

4 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First Name
Position of person signing this statement (please print)	
Authorized signature X	Date (dd-mm-yyyy) — —
Telephone number — —	Fax number — —

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health and work](http://www.sunlife.ca/health-and-work)

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For all other provinces or territories

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

Kitchener - Waterloo:
Fax: 1-866-209-7215
PO Box 100 Stn C
Kitchener ON N2G 3W9