Sun Life Insurance and Annuity Company of New York
Long Term Disability Claim Packet – Attending Physician

Instructions for the Attending Physician

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

The Attending Physician must:

☐ Complete, sign and date the Attending Physician's Statement

☐ Submit the Attending Physician's Statement directly to Sun Life Financial

Mail or fax the completed claim form to:

Sun Life Insurance and Annuity Company of New York
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 Warning

State law requires that we notify you of the following:

Any person who knowingly and with intent to defraud any insurance company or any 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sun Life Insurance and Annuity Company of New York
Long Term Disability Claim Packet – Attending Physician

Attending Physician's Statement – Physical conditions only

1 Patient Information

Please print clearly

The patient is responsible for any costs associated with the completion of this form.

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Do you believe this patient is competent to endorse checks? .... ☐ Yes ☐ No		

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications

Objective findings/investigative testing (i.e., x-rays, EKGs, MRIs, laboratory data, etc.)

Subjective findings

Date symptoms first appeared or date of accident	If injury due to a motor vehicle accident, indicate in which state the accident occurred.	
Patient's Height:	Patient's Weight:	Blood Pressure:

Is condition due to injury/sickness arising out of patient's employment?... ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians (if applicable)

If pregnancy, please provide the following information:
- Expected delivery date: ________ • Actual delivery date: ________ • C-Section? ☐ Yes ☐ No

Describe any complications that would extend this disability longer than a normal pregnancy

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit	Date of last visit	Date of last examination

Frequency of treatment .... ☐ Weekly ☐ Monthly ☐ Other (please specify: ________________)

Description of Treatment

4 Progress

Patient: ☐ Unchanged ☐ Improved ☐ Retrogressed ☐ Ambulatory ☐ Bed confined

If retrogressed, please explain:

Has patient been hospital confined?........ ☐ Yes ☐ No	From:	To:

If yes, provide name of hospital

Continued on next page

5 Restrictions and Limitations

Please note that additional occupational information may be required.

Patient is able to use hand for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

In a typical work day, patient is able to:

	Continuously	Frequently	Occasionally	Negligible
Drive	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Lift _____ lbs.	☐	☐	☐	☐
Carry _____ lbs.	☐	☐	☐	☐

Is the patient capable of working within these restrictions/limitations? .... ☐ Yes ☐ No

Physical Impairment

☐ No limitation of functional capacity - (no restrictions)

☐ Medium capacity - (lifting, carrying, pushing, pulling 20-50 lbs. occasionally; 10-25 lbs. frequently; or up to 10 lbs. constantly)

☐ Light capacity - (lifting, carrying, pushing, pulling 20 lbs. occasionally; 10 lbs. frequently; or negligible amount constantly. Can include walking and/or standing frequently even if the weight is negligible. Can include pushing or pulling of arm or leg controls.)

☐ Sedentary capacity - (lifting, carrying, pushing, pulling 10 lbs. occasionally. Mostly sitting, may involve standing or walking for brief periods of time.)

☐ Comments (please explain):

Cardiac (if applicable) - Functional capacity (American Heart Association)

☐ No limitation ☐ Marked limitation

☐ Slight limitation ☐ Complete limitation

Continued on next page

6 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ longer

7 Remarks

Please use this space for any additional comments.

8 Certification and Signature

Remember to provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 2 of this packet.

Name of Attending Physician (first, middle initial, last)			Degree/Specialty	
Street address	City		State	Zip Code
Tax ID number	Telephone number		Fax number	
Attending Physician Signature X			Date	

Please be sure to return the completed Attending Physician's Statement to:

Sun Life Insurance and Annuity Company of New York
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Attending Physician's Statement – Behavioral health conditions only

1 Patient Information

Please print clearly

The patient is responsible for any costs associated with the completion of this form.

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Do you believe this patient is competent to endorse checks? .... ☐ Yes ☐ No		

In order to evaluate a claim for Disability Benefits submitted by your patient, we need more detailed information about his/her medical condition. Please respond to the following questions. Thank you.

Axis I ____________ DSM IV TR Code ____________
Axis II ____________ DSM IV TR Code ____________
Axis III ____________ No Code ____________
Axis IV ____________ No Code ____________
Axis V ____________

GAF: Current:	Baseline:	Highest in past year:

2 Treatment Information

When did the patient first experience psychiatric symptoms?
What was the first date you treated the patient for symptoms?
Name of first treating physician for symptoms (first, middle initial, last)
Please list facilities and dates of any hospitalization, intensive outpatient program, or partial hospitalization program.
What was the diagnosis at that time?
Current diagnosis
Describe the patient's current psychiatric symptoms and mental status evaluation.
Is the patient's current condition related to chemical dependency? .... ☐ Yes ☐ No If yes, please describe

Continued on next page

2 Treatment Information continued

Has there been any psychological testing? If available, provide results. If not, why? Are there any plans in the future to perform testing?
Current treatment methods/treatment plan, please describe.
List medications with dosages. Please note any recent changes.
Please describe patient's response to treatment to date. (Include any past treatments and additional methods of treatment being considered.)
Please describe if the patient's psychiatric condition is limiting the patient's functional capacity.

3 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ longer

4 Certification and Signature

Remember to provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 2 of this packet.

Name of Attending Physician (first, middle initial, last)			Degree/Specialty
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Please be sure to return the completed Attending Physician's Statement to:

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Sun Life Insurance and Annuity Company of New York
Wellesley Hills, MA 02481
1-800-247-6875

Sun Life Financial®

Sun Life Insurance and Annuity Company of New York

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Insurance and Annuity Company of New York ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application or to evaluate your claim. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, healthcare providers, medical professionals, hospitals, clinics or other medical or healthcare related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Insurance and Annuity Company of New York
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481

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