

SHORT-TERM DISABILITY



How to file your short-term disability claim

If you are going to be out of work – or are already out of work – due to an illness or injury, you may be eligible to receive short-term disability benefits. Here is some helpful information to get your claim started:

What we may need...

... from you

- **Third Party Authorization form.** This form allows for the release and disclosure of information about you that we may need to evaluate your claim; for example, it allows us to obtain your medical records if we need them. Please note, if you do not complete the Third Party Authorization form, you will be responsible for obtaining any additional medical information we might need to process your claim.
- **Car accident report.** If your disability is a result of a car accident, you will need to provide the police report from the accident.

... from your doctor

- **Attending Physician's Statement (APS).** This form provides us with specific medical information about your condition and expected recovery.
- **Medical notes or test results.** Notes and results related to your condition may help us make the most informed decision.
- **Treatment notes.** These are notes from your doctor or any other treating provider (such as a counselor or therapist if your claim is due to a psychiatric condition).

Filing your claim by phone

Step 1.

Contact your Benefits Administrator to report your disability, and check whether you are insured under the policy and eligible to file a claim for short-term disability benefits.

Step 2.

Call our toll-free number at 866-806-3619, Monday through Friday, from 8:00 a.m. to 8:00 p.m. ET.

A client service specialist will ask you a series of questions relating to your occupation and disabling illness or injury. You will also be asked how you would like to receive the Third Party Authorization form.

Use the following checklist to help you be prepared to provide information and answer questions regarding the cause of your disability.


Diagnosis information

- Doctor's name
- Doctor's phone #
- Doctor's fax #
- First date of treatment for diagnosis
- The type of treatment you are receiving
- Last day of work

If applicable

- Hospital admittance date
- Hospital discharge date
- Date of surgery
- Type of surgery
- Source of other income
- Date of other income
- Amount of other income

What is DocuSign?
DocuSign is a tool that allows you and your physician to complete and sign forms electronically. It is initiated through email.



Step 3.

To process your request for benefits, an Attending Physician Statement (APS) will be requested from your treating physician. Sun Life will provide an APS to your doctor. **It is your responsibility to follow up directly with your doctor to make sure this form is completed and returned to Sun Life in a timely manner.** Your claim cannot be considered for payment until your doctor completes this form either electronically through DocuSign or by faxing it to Sun Life at 781-304-5599.

Step 4.

In order for Sun Life to be able to obtain any additional medical information on your behalf, you must complete the Third Party Authorization form that was sent to you. You can complete it electronically through DocuSign. Or, you can make a copy of the completed Third Party Authorization form and submit it to Sun Life by email at myclaimdocuments@sunlife.com, by fax to 781-304-5599, or by mail to:

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

What can I expect from Sun Life?

We'll do an initial assessment

As soon as we receive your completed Employee's Statement and Attending Physician's Statement, we will consider a number of different factors when assessing your claim, including policy eligibility requirements, your job requirements, your medical information, and how your illness or injury affects your ability to perform your job. As part of the review, we may ask you, your doctor, or your employer for more information.

We'll let you know the status

Upon review of your claim, we will update the status of your claim to pending, approved, or denied. Here's what each of those mean:

- **Pending.** For some claims, we may determine that we don't have enough information to make a proper decision. If this is the case, we try to get the additional information we need as quickly as possible. We will let you know as soon as we determine that more information is needed.
- **Approved.** We determine that part of your claim or your entire claim is approved according to your employer's short-term disability plan. We will call you to notify you that we have approved your claim.
Please note: If your claim is approved and you provide an estimated or actual return-to-work date, the online status will change from "Approved" to "Closed. The claimant has or will have returned to work." This status means that you will receive payments until the anticipated return-to-work date shown online.
- **Denied.** If we determine that your claim is not approved, we will notify you in writing and provide the reasons for our decision. If you do not agree with our decision, there is an appeal process in place.

You can check your claim status, view payment status, or see if there are messages posted about your claim by signing into www.sunlife.com/ account, clicking on *View claim status*.

After you have initiated your claim, all inquiries or follow-up questions can be directed to our short-term disability client service number at 866-806-3619, Monday through Friday, from 8 a.m. to 8 p.m. ET.

1. If in New York, browse the list under "Employee benefits forms if located within New York."

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI). Product offerings may not be available in all states and may vary depending on state laws and regulations.

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Sun Life Assurance Company of Canada

Short-Term Disability Claim Statement - Employer



Instructions

Please complete, sign and date this form, including the authorizations, and return it to us by e-mail, mail, or fax.

You may also file this form online at www.sunlife.com/us, click on **Submit a Disability Claim**

E-mail: myclaimdocuments@sunlife.com

Mail: Sun Life Assurance Company of Canada, 96 Worcester Street, Wellesley, MA 02481

Fax: 781-304-5599

Group policy number

1 General information

Name of employer			
Street Address	City	State	Zip code
Name and address of division where employee works (if different from above)			

2 Employee's information

Name of employee (first, middle initial, last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number
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3 Employment and claim information

Date hired:	Start date of insurance:	Date last worked before disability:	Hours worked last day:
Employee's job title			
How would you classify the employee's occupation? <input type="checkbox"/> Sedentary (1-10lbs) <input type="checkbox"/> Light (11-20lbs) <input type="checkbox"/> Medium (21-50lbs) <input type="checkbox"/> Heavy (51+ lbs)			
List employee's major job duties (include a copy of the job description if available)			
Indicate the days per week the employee regularly works. <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7			
Indicate daily hours the employee regularly works <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Other:			
Has employee's employment terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," termination date:			
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Workers' Compensation carrier			Phone number
Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," return date: <input type="checkbox"/> Full-time (full capacity) <input type="checkbox"/> Full-time (partial capacity) <input type="checkbox"/> Part-time (attach payroll ledger)			

4 Salary and benefit information

How was the employee paid? (check one)

<input type="checkbox"/> Hourly \$ per hour:	<input type="checkbox"/> Salaried \$ per week:
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Other work-related income:

Commissions \$	Bonuses \$	Overtime \$
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How does the employee contribute toward the premium? PRE-tax POST-tax Employee does not contribute
If employee contributes, please provide percentage %

5 Other income information

Check all that apply.

Source of Income	Payment Amount	Weekly or monthly	Payment Coverage (mm/dd/yyyy)
<input type="checkbox"/> Sick Pay	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Salary Continuance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> State Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Workers' Compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Unemployment	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Social Security Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Disability/Retirement Pension	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Other:	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:

6 Certification and signature

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	E-mail address
Title	Phone number
Signature X	Date signed (mm/dd/yyyy)

7 Fraud warnings

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, 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.

7 Fraud warnings, continued

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 Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

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.

RI: 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.

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.

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.

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.

Contact us



By mail

Sun Life Assurance Company of Canada
96 Worcester Street
Wellesley Hills, MA 02481



By fax

781-304-5599



By e-mail

myclaimdocuments@sunlife.com



www.sunlife.com/us



Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET

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Short-Term Disability Claim Statement – Employer

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9/22

Claimant:

DOB:

Policy no.:

CC no: