Plan Member's Statement
Claim for Short-Term Disability benefits

Sun Life Financial

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

In order to avoid any delays in the assessment of your claim, we also require the Plan Sponsor's and Attending Physician's Statements to be submitted. **Any cost for information to substantiate this claim will be your responsibility.**

If disability benefits under your Short-Term Disability Plan are taxable, your Social Insurance Number is required for the issuance of the applicable tax information slip(s).

First name	Last name (Quebec residents – maiden name)	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
			– –

Address (street number and name)	Apartment or suite

City	Province	Postal code

Occupation	Job title	Social Insurance Number

Home telephone number	Alternate telephone number	Email address
– –	– –	

2 Plan Sponsor information

Contract number	Member ID (EMPLOYEE #)	Division/Billing group number
100258		504

Company name
TECK COAL LTD - FORDING RIVER OPERATIONS

Address (street number and name)
PO BOX 100

City	Province	Postal code
ELKFORD	B.C.	V0B 1H0

Contact person	Contact's telephone number	Ext.
NADINE KIRSCHENMAN,COORDINATOR,HR	250 865 5057	

3 About your illness or injury

You must notify Sun Life Assurance Company of Canada if,

- your medical condition improves so that you are able to work
- you begin working again either as an employee or as a self-employed person.

When did your symptoms first appear? Date (dd-mm-yyyy) – –

Have you ever had the same or similar illness or injury? ☐ No ☐ Yes
If yes, please explain and give dates.

On what date did you first see a doctor for this illness? Date (dd-mm-yyyy) – –

3 About your illness or injury (continued)

Please describe your present illness or injury and how it prevents you from working. Include a description of which duties of your job you are *unable* to perform because of your illness or injury. As well, list the duties of your job you *are* able to perform. (Attach extra sheets, if necessary.)

When was your last day of full-time duties/hours? Date (dd-mm-yyyy) – –

When was your last day of modified work (if applicable)? Date (dd-mm-yyyy) – –

What is the date you returned or expect to return to work? Date (dd-mm-yyyy) – –

During this period, have you worked at any occupation or employment? ☐ No ☐ Yes If yes, please explain.

What are the current symptoms preventing you from working?

Is your condition related to pregnancy?
☐ No ☐ Yes If yes, what is your delivery date? Date (dd-mm-yyyy) – –

Please describe your complications, if any.

4 Disability as a result of an accident

1. Is your disability the result of an accident?
   ☐ No If no, continue with the next section "**Your other income**".
   ☐ Yes If yes, what was the date, time and location of the accident?

Date (dd-mm-yyyy) – –	Time	Location

2. Were you working for your employer at the time of the accident? ☐ Yes ☐ No Please describe how your illness or injury occurred.

Is your illness or injury due to a motor vehicle accident? ☐ No ☐ Yes If yes, please enclose a copy of the accident report.

Name of insurance adjuster		
Auto carrier	Contract/Policy number	Telephone number – –

4 Disability as a result of an accident (continued)

3. If your disability is the result of an accident, are you taking legal action against any other person or organization?

☐ No If no, explain why you are not taking legal action.

☐ Yes If yes, please complete the following:

Name of lawyer		Telephone number
		– –
Address	**City**	**Province** / **Postal code**

On what date did the legal action start? Date (dd-mm-yyyy) – –

Has a settlement been reached? ☐ No ☐ Yes If yes, please attach a copy of the terms of the settlement.

5 Your other income

Please list any amounts of money you are currently receiving or expect to receive each week or month from the following sources. We may take some of these amounts into consideration when we calculate your Short-Term Disability benefit.

Source	Are you eligible for this benefit?		Insurance Co. ‡ Policy Number	Have you applied for this income?		Are you receiving or do you expect to receive this income?		Amount per ☐ Week ☐ Month
	Yes	No		Yes	No	Current	Expected	
Any other disability insurance (i.e. WCB/WSIB/CSST, Union Disability Benefit, Creditor, Credit Cards, etc.)	☐	☐		☐	☐	☐	☐	‡
Auto Insurance	☐	☐		☐	☐	☐	☐	‡
Other Group/Association/ Individual Plans	☐	☐		☐	☐	☐	☐	‡
Employment Insurance	☐	☐		☐	☐	☐	☐	‡
Quebec Parental Insurance Plan	☐	☐		☐	☐	☐	☐	‡
Canada/Quebec Pension Plan	☐	☐		☐	☐	☐	☐	‡
Employer Disability, Severance or Retirement	☐	☐		☐	☐	☐	☐	‡
Any other Accident/Group/ Association/Government Disability Benefit	☐	☐		☐	☐	☐	☐	‡
Other (specify) i.e. in Quebec, Criminal Victims Benefits	☐	☐		☐	☐	☐	☐	‡

6 Automatic deposit of your disability payments

This service is subject to the approval of your claim.

We offer you, for your convenience, the option of your benefit payments being directly deposited into your account at any bank, trust company, caisse populaire or credit union in Canada. **If you would like to have your payments directly deposited into a chequing account we require a personalized void cheque with your name pre-printed on the cheque.** Please check with your Benefit Administrator to determine if this option is available to you.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

7 Your declaration and authorization

Fraudulent claims are costly for all participants in a benefit plan and we will verify the accuracy of the information given in support of your claim.

You must also sign and complete the Member's Authorization on the Attending Physician's Statement.

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

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my claim. I authorize Sun Life and its reinsurers to collect, use and disclose information needed for underwriting, administration, adjudicating claims under this Plan to any person or organization who has relevant information pertaining to my claim including health professionals, institutions, investigative agencies, insurers and, where applicable, my Plan Sponsor. I agree that Sun Life and my Plan Sponsor may also share financial information related to my claim for purposes relevant to the management of this Plan. I understand that information about me pertaining to my claim may be reviewed in the event this Plan is audited.

I authorize Sun Life and my Plan Sponsor and their medical consultants to collect, use and disclose among them information about me, **except** for details related to diagnosis, treatment or medication, that is relevant to my claim, for the purposes described above as well as for the purpose of planning and managing my rehabilitation and return to work.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include my Plan Sponsor, regulatory bodies, government organizations, and other insurers, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about me to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants.

Member's last name (please print)	First name

Member's signature	Date (dd-mm-yyyy)
...	

Visit our website:
www.sunlife.ca/
health and work

To ensure prompt submission, please fax this form, along with any other information in support of your claim that you would like to submit, 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 are not sure which office to send your information to,

Group Disability Claims

Claims submission mailing address (Vancouver)	Sun Life Assurance Company of Canada Group Disability Management Office P.O. Box 48810 Stn Bentall Vancouver, BC V7X 1A6
Toll Free Number	1-866-246-4153
Fax Number	1-866-639-7829

8 Keeping your information confidential

We are responsible for all personal information in our possession, including information transferred to a third-party service provider or agent, so that we can provide you with a product or service. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons, whether or not they are located in Canada, are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Attending Physician's Statement
Short-Term Disability Claim

Sun Life Financial

Purpose of Statement This Statement is to assist Sun Life Assurance Company of Canada in making a decision on your patient's claim for disability benefits.

Return address Return this Statement to your patient or fax it to the confidential fax number that appears below for the appropriate Sun Life Assurance Company of Canada Disability Management office. Please confirm the appropriate Disability Management office with your patient. You do not need to mail information that you fax. Please retain the original copy for your records.

Vancouver:
Fax: 1-866-639-7829
PO Box 48810 Stn Bentall
Vancouver BC V7X 1A6

1 Plan Member information and authorization to be completed by patient

Last name (Quebec residents – maiden name)	First name	Home telephone number	Alternate telephone number

Address (street number and name)	Apartment or suite

City	Province	Postal code

Plan Sponsor name	Contract number	Member ID number(EMPLOYEE #)
TECK COAL LTD - FORDING RIVER OPERATIONS	100258	

Height	Weight	Date of birth (dd-mm-yyyy)	Last date worked (dd-mm-yyyy)	Date returned to work or expected return to work date (dd-mm-yyyy)

I authorize my doctor to collect, use and disclose my personal information to Sun Life Assurance Company of Canada, its agents and service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature	Date (dd-mm-yyyy)

2 Attending Physician's Statement

Note to Physician – If your patient has returned to work or will return to work within 4 weeks of the Last Date Worked, complete Page 1 only AND SIGN ATTENDING PHYSICIAN'S ACKNOWLEDGEMENT • END THIS FORM. For absences expected to be greater than 4 weeks, please complete Pages 1 and in full

Diagnosis
Primary

Secondary:

If childbirth: expected or actual delivery date (dd-mm-yyyy) ☐ Vaginal ☐ C-Section

Occupational illness/injury Is condition arising from employment? ☐ Yes ☐ No

Start dates of current work absence
Date of first visit during current period of absence (dd-mm-yyyy)
First date of work absence due to condition (dd-mm-yyyy)

Hospitalization
Has your patient been hospitalized ☐ Yes ☐ No Date admitted (dd-mm-yyyy)
Have they had day surgery? ☐ Yes ☐ No Date discharged (dd-mm-yyyy)
Name of institution:
If surgery was performed, please provide date and description of surgery
Date (dd-mm-yyyy) Description Type of anaesthetic

Treatment (Drug, dosage, physiotherapy, other)

Prognosis Please provide the prognosis for recovery

3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History „ Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) – –

Visits „ Frequency of visits ☐ Weekly ☐ Monthly ☐ Other

Symptoms „ Describe current symptoms, severity and frequency.

Investigations „ **Please attach copies of all relevant:**

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Are tests/investigations pending? ☐ Yes ☐ No If Yes, expected date of receipt (dd-mm-yyyy) – –

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist Specialty Date of visit (dd-mm-yyyy) – –

Restrictions and limitations „ Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Complications and other condition(s) „ Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment „ To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

Competency „ In your opinion, is your patient competent to manage his/her own affairs? ☐ Yes ☐ No

Prognosis „ Please provide the prognosis for recovery (if not completed on page 1)

4 Attending Physician's acknowledgement

I acknowledge that the information in this Statement will be kept in a group disability benefits file with Sun Life Assurance Company of Canada and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp
Address			
Telephone number – –	Fax number – –		
Physician's signature		Date signed (dd-mm-yyyy) – –	

NOTE: The patient is responsible for any charge made for the completion of this form.

Canadian Life and Health Insurance Association Inc. Association canadienne des compagnies d'assurances de personnes inc.