

1 Instructions for the attending physician

Be sure to complete, sign, date, and submit the Attending Physician Statement directly to Sun Life Financial. Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.

2 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, NM, RI, 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.

2 Fraud warnings, continued

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.

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.

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 and 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.

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.

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.

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.

Claiming benefits for: Employee Spouse/partner Child

3 Patient information

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

Patient name (first, middle initial, last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Group policy number
Social Security number	Date of birth (mm/dd/yyyy)		

Do you believe this patient is competent enough to endorse checks? Yes No

Insured name (first, middle initial, last)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security number	Date of birth (mm/dd/yyyy)	

4 Diagnosis and treatment

Patient's diagnosis	ICD9
Surgical procedure (if any)	CPT
Cause of illness	
Date diagnosis made (mm/dd/yyyy)	Date first consulted for this illness (mm/dd/yyyy)

Has the patient had the same or similar condition? Yes No

If "Yes," indicate first treatment date (mm/dd/yyyy): _____

If this critical illness resulted in death, please provide the date of death (mm/dd/yyyy): _____

5 Additional information

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If you need a consultant, what would be a convenient day/time for our benefits administrator or medical doctor consultant to call you? _____

6 Other treating providers (if applicable)

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

7 Required supporting medical documentation:

Cancer: Oncology records to include staging exam(s), pathology report, treatment plan, and diagnostic testing report(s) (e.g. PET scan).

Stroke: Hospital admission/discharge summaries, diagnostic testing reports (i.e. MRI CT Scan) and medical records from date of diagnosis through at least two months post event.

Heart Attack: Hospital admission/discharge summaries, diagnostic testing reports (i.e. EKG, ECHO) and laboratory reports (i.e. cardiac enzymes).

Heart Transplant, Aortic surgery, Coronary Artery Bypass surgery, Coronary Artery Angioplasty: Hospital admission/discharge summaries and operative reports.

End Stage Heart Failure: Hospital admission/discharge summaries, transplant consultation and cardiology records from date of diagnosis through current.

Coronary Artery Disease: Hospital admission/discharge summaries, and cardiology consultation records, including recommendations and treatment plan.

Paralysis: Hospital admission/discharge summaries and physical exam findings that include neurologic assessment and testing from date of diagnosis through at least four months post event.

Severe Burns: Hospital admission/discharge summaries and medical documentation that specifies degree and percentage area of burns.

Coma: Hospital admission/discharge summaries and physical exam findings, including Glasgow Coma Scale findings from date of diagnosis through at least seven days post event.

Major Organ Failure: Medical records from specialty physician(s) from the time of diagnosis through current.

Benign Brain Tumor: Neurology treatment records to include diagnostic test results and neurological exam findings.

The following are for children only:

Cerebral Palsy, Congenital Heart Disease, Cystic Fibrosis, Muscular Dystrophy, and Type 1 Diabetes Mellitus:

Treatment notes from treating specialist(s) from date of diagnosis to at least two months post diagnosis to include appropriate diagnostic test results and laboratory reports through at least two months post diagnosis.

8 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 attending physician (first, middle initial, last)		Degree/specialty	
Street address		City	State Zip code
Tax ID number	Phone number	Fax number	
Attending physician signature X			Date (mm/dd/yyyy)

Contact us



By mail

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By fax

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www.sunlife.com/us



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