WELLESLEY COLLEGE
REQUEST FOR FAMILY OR MEDICAL LEAVE

Employee's Name: _____

Reason for Leave:		**Check One:**
1.	Employee's own serious health condition	_____
2.	Serious health condition of your:	
	Child_____(Name)	_____
	Spouse_____(Name)	_____
	Parent_____(Name)	_____
3.	Birth of child	_____
4.	Adopting or placement of a child for foster care	_____

Anticipated Date of Leave: _____

Anticipated Date of Return: _____ (Employee to complete)

Certification:
If your need for leave is due to either your serous health condition or the need to care for a seriously ill child, spouse, or parent, you must provide medical certification by a health care provider before or at the commencement of your leave stating:

1. the date on which the condition commenced;
2. the probably duration; and
3. medical facts surrounding the condition

The form for medical certification will be available form Human Resources. For your own medical leave the certification must also include a statement by your health care provider that you are or will be unable to perform your job functions.

For family medical leave, the medical certification should include an estimate of the amount of time you will be needed to care for your child, spouse, or parent.

The Company may require periodic recertification during the leave, and may request a second medical opinion at Company expense. If the first and second opinions differ, the Company may require the opinion of a third health care provider (approved by both the Company and you) whose opinion will be binding.

If the need for leave does not allow for time to present prior medical certification, certification should be provided as soon as possible after the commencement of the leave.

Employee Acknowledgments:

1. My qualified health care provider currently anticipates (and has documented in writing) that I will be physically/mentally able to return to work on the first day following the date my FMLA leave ends.
2. I currently intend to return to work on the first day following the date my FMLA leave ends, if my qualified health care provider gives me medical clearance.
3. If I accept employment elsewhere or become self-employed during my FMLA leave, I understand that my employment may be terminated automatically.
4. CHECK "A", "B", **OR** "C" below

   (A) During my FMLA leave of absence, I want my group health insurance coverage to remain in effect, and I understand that in order for my group health insurance coverage to remain in effect, I agree I will pay the current amount of my contribution (if any) to the insurance premium in advance or weekly, and I also hereby authorize the Company to deduct the current amount of my contribution to the insurance premium from any paychecks which I receive from the Company, if necessary. **If you select choice "A" check here:**_____

   (B) I do not want my group health insurance coverage to remain in effect during my FMLA leave. **If you select choice "B", check here:**_____

   (C) I do not have group health insurance coverage through the company. **If you select choice "C", check here:**_____

5. I understand I am eligible to receive holiday pay or accrue vacation, sick, or personal time during my FMLA leave.
6. I understand my accrued, but unused vacation, sick or personal time (if any) may be applied to my FMLA leave at its commencement, unless my leave runs concurrently with a worker's compensation leave.
7. If my absence is the result of a workplace injury which is covered by worker's compensation, the fact that my FMLA leave will run concurrently with my worker's compensation leave will not negatively impact or affect my rights under worker's compensation laws.

_____ _____

Employee Signature Date

_____ _____

Supervisor's Signature Date

Forms to be returned to: Wellesley College
106 Central Street
Wellesley, MA 02481

Faculty: return form to the attention of Ruth Frommer, Office of the Provost
Staff (admin. & union): return form to the attention of JoAnne O'Beirne, Human Resources

Family Medical Leave of Absence/Disability time off

If you are going to be out for more then 2 weeks due to your own serious medical condition and will qualify for Disability while you are out please make sure to complete the form below and return it to the Human Resources department prior to going out of work.

- While you are out on leave you must make arrangements with the Human Resources office to pay for the employee portion of your health and/or dental benefits, if applicable.

  Benefits Payment Options:

  Please check off which option you would prefer and return this form to the Human Resources office by fax, mail or drop off.

  _____ Please supplement my disability pay using vacation/personal time so that I am receiving full pay while I am out due to my work related injury.

  _____ Please supplement my disability pay with vacation/personal time to cover my health/dental benefits.

  _____ I do not wish to supplement my disability pay and please bill me for portion of my health/dental benefits.

**If you run out of time to continue to supplement we will then start to bill you for your portion of your health and/or/dental benefits. If you have questions/concerns about paying for your benefits please contact our Benefits Specialist at 781-283-2212.

Important Please Read: If the Human Resources dept does not hear from you directly or receive this form back from you then you will go into an unpaid status and will be automatically billed for you benefits.

Please feel free to call us at 781-283-3303 with any other questions or concerns.

_____ _____

Employee Signature Date

_____

Print Name

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

   _____

   _____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Your Rights
under the
Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

If you have access to the Internet visit our FMLA website: **http://www.dol.gov/esa/whd/fmla.** To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone;** or log onto our Home Page at **http://www.wagehour.dol.gov**.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
Revised August 2001

*U.S. GOVERNMENT PRINTING OFFICE 2001-476-344/49051

FREQUENTLY ASKED QUESTIONS ABOUT FMLA (Family and Medical Leave Act)

Although Wellesley College's leave policies were generally more generous than the Family and Medical Leave Act of 1993, the College nonetheless must comply with the documentation requirements of the Act. To help explain the impact of the FMLA on the College's leave policies we are providing the following Frequently Asked Question (FAQ) section.

What is the Family and Medical Leave Act ("FMLA")?
The Family and Medical Leave Act of 1993 generally took effect on August 5, 1993. It provides that eligible employees who have worked for the College at least 1,250 hours during the 12 months immediately prior to the request may be granted up to 12 weeks of unpaid leave during the following 12-month period. An employee must use any accumulated unused sick leave during his or her FMLA leave.

What are the reasons to take a FMLA leave?
- to care for the employee's newborn child or child placed with the employee for adoption or foster care;
- to care for the employee's spouse, domestic partner, son or daughter, or employee's parent who has a serious health condition; or,
- for a serious health condition that makes the employee unable to perform the employee's job.

What is a "serious health condition"?
A "serious health condition" is an illness, injury, or physical or mental condition involving inpatient care or continuing treatment by a health care provider for a period that includes incapacity. Absences for short-term illnesses and routine healthcare are not covered under the FMLA.

How are health benefits provided during the leave?
For the duration of FMLA leave the College maintains the employee's health coverage at the group rate provided that the employee continues to co-pay health premiums timely while on leave.

Do I need to provide a medical certification?
The College requires medical certification of the condition necessitating FMLA leave and its estimated duration. This is the case whether the leave is to care for the employee's own medical condition or that of a family member. The College also requires that an employee present a medical certification from his or her physician that he or she is able to return to work.

When and how do I apply for a FMLA leave?
The College expects employees to provide 30 days' advance notice for leaves that are foreseeable. If illness or injury strikes unexpectedly, the notice should be provided at the first available opportunity. The necessary application forms and medical forms are available in the Human Resources Office and can be obtained by calling x2231. (Faculty should contact the Office of the Dean of the College.)

Is FMLA only unpaid leave?
The College requires that employees substitute any accrued, unused sick time. Leave **may also** be covered by accrued vacation or personal time, or STD, depending upon the reason for and the length of the leave. If there is no accrued time available the leave will be unpaid.

[Wellesley College provides a benefit of six weeks of paid parental leave for a woman who gives birth or an administrative staff member who takes primary responsibility for the care of a biological or newly adopted child. Union employees are eligible for Parental Leave as described in the College-Union Agreement. Faculty Parental Leave is administered by the Office of the Dean of the College and is described in the Faculty Handbook.]

What is my responsibility as a manager when an employee asks for leave or is out of work for five consecutive days?

As a Manager it is your responsibility to inform Human Resources when an employee is out of work for 5 consecutive days or requests a leave of absence. The Manager is also responsible for informing Human Resources if the dates of the leave change in any way.

What is my responsibility as a manager during an employee's leave?

1. **Documentation**

   The manager is responsible for directing the employee to Human Resources **prior** to the start of a leave to obtain a medical certification and leave application.

2. **Payroll**

   a. If your employee is on an **intermittent leave** (a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee for a limited period), then the manager must assure the appropriate time off is reflected on Web Time Entry.

   b. If your employee is on a **full leave**, payroll of the employee is handled by Human Resources on a weekly or monthly basis.

What is my responsibility as a manager when an employee Returns to Work following a leave?

As a manager it is your responsibility to direct the employee to forward their medical clearance to Human Resources prior to their return to work date. Human Resources will then notify the manager of the expected return to work date.

January 2007

Sun Life Assurance Company of Canada
Short Term Disability Claim Packet

Sun Life Financial®

Instructions

☐ Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**

- Employer Statement
- Employee Statement
- Attending Physician Statement
- Authorization Statements

An STD claim should be submitted for a disability absence that may extend beyond the required elimination period.

☐ Prefill the Group STD policy number and Employer name on the Employee and Physician Statements.

☐ Employer is required to include the following (as applicable):

- Enrollment Form
- Job Description
- Worker Compensation Report
- Return-to-Work slip
- W2
- Payroll Ledger

☐ Physician must completely fill out and sign the Physician Statement.

☐ Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim or check on a status online go to www.sunlife.com/us.
- Click on "Submit a Disability Claim"
- OR **Fax to: 781-304-5599**

Employer's Statement

Group STD policy number

1 General Information

Please print clearly.

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

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employer (parent company name)		Employer phone number	
Wellesley College		781-283-3303	
Employer street address	City	State	Zip code
106 Central Street	Wellesley	**MA**	02481

Name of employee (first, middle initial, last) ☐ M ☐ F		Social Security number	
Employee street address	City	State	Zip code

Employee phone number	Preferred form of contact	Date of birth
Home Work	☐ Home phone ☐ Work phone ☐ Mail	

2 Employment and Claim Information

	Is condition due to injury/sickness caused by patient's employment? ☐ Yes ☐ No ☐ Unknown
	Date hired | Start date of insurance | Date last worked before disability | Hours worked last day
	Employee job title (Attach employee's formal job description)
	List employee's major job duties
	How would you classify the employee's occupation? ☐ Sedentary (1-10 lbs) ☐ Light (11-20 lbs) ☐ Medium (21-50 lbs) ☐ Heavy (51+ lbs)
	Indicate days per week the employee regularly works? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
	Indicate daily hours the employee regularly works. ☐ 8 ☐ 9 ☐ 10 ☐ Other:
Attach Return-to-Work slip from physician.	Has employee terminated employment? ☐ Yes ☐ No If yes, termination date:
	Has employee returned to work? ☐ Yes ☐ No If yes, return date: If yes, did employee return: ☐ Full-Time (full-capacity) ☐ Full-Time (partial capacity) ☐ Part-Time (attach payroll ledger)
Attach Worker's Compensation Report and Reward/Denial notice.	Has Worker's Compensation claim been filed? ☐ Yes ☐ No
	Name of Worker's Compensation carrier | Phone number

3 Salary and Benefits Information

How was the employee paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per week:

Other work related income:

Commissions	Bonuses	Overtime
$	$	$

If employee contributes to STD premium, attach a copy of employee enrollment form

How does employee contribute toward the STD premium?

☐ PRE-tax ☐ POST-tax ☐ Employee does not contribute

If employee contributes, please provide percentage..... _____ %

4 Information About Other Income

Indicate whether the employee is currently receiving, or entitled to receive, benefits from any of these sources.

Check all that apply.

	Source of income	Payment Amount	Weekly or monthly?	Payment Coverage (M/D/Y)
☐	Sick pay	$	☐ Wkly ☐ Mthly	From: To:
☐	Salary continuance	$	☐ Wkly ☐ Mthly	From: To:
☐	State Disability	$	☐ Wkly ☐ Mthly	From: To:
☐	Worker's Compensation	$	☐ Wkly ☐ Mthly	From: To:
☐	Unemployment	$	☐ Wkly ☐ Mthly	From: To:
☐	Social Security Disability	$	☐ Wkly ☐ Mthly	From: To:
☐	Other:	$	☐ Wkly ☐ Mthly	From: To:

5 Certification and Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Name of person completing this form Laura Andrews	E-mail address landrews@wellesley.edu
Title Employment Coordinator	Phone number 781-283-3303
Signature (original signature required) X	Date signed

Sun Life Assurance Company of Canada
Short Term Disability Claim Packet

Employee's Statement

Group STD policy number
224991

1 General Information

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

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employee (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Employee street address	City	State / Zip code
Home phone: Cell phone: Work phone:	Preferred form of contact: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Mail	
Name of employer (parent company name)		

2 Information About the Condition Causing Your Disability

Last day worked before disability	Date first treated by Physician	Date expected to return to work ☐ FT ☐ PT
Did you require Emergency Room care for your condition? ☐ Yes ☐ No If yes, Hospital name: Date: Phone:		
Were you confined to a hospital for this condition? ☐ Yes ☐ No		
If yes, include the hospital name	Hospital phone	
Date(s) of confinement: From: To:		

Select the appropriate type of condition, and provide details:

☐ **Pregnancy**
Expected due date: Actual due date:
Delivery type: ☐ Normal ☐ C-Section
Complications:

☐ **Work-related injury/sickness**
Date of first symptom/injury:
Where occurred:
Cause of injury/sickness:
Do you intend to file for Workers Compensation? ☐ Yes ☐ No
If yes, what is the status: ☐ Denied ☐ Approved ☐ Pending ☐ Appealed

☐ **Sickness** First date of symptom:
Type of sickness:
Have you experienced a symptom in the past? ☐ Yes ☐ No Date:

2 Information About the Condition Causing Your Disability continued

☐ **Motor vehicle accident** - complete only if applicable
Date occurred: Time: ☐ AM ☐ PM
Was a citation issued to you? ☐ Yes ☐ No
If yes, type of citation:

How injury occurred:
Where injury occurred:

Name of your car insurance carrier:
Phone number:

Are you receiving compensation from a car insurance carrier? ☐ Yes ☐ No
If yes, Date: From: To:

☐ **Other injury**
Date occurred: Where occurred:
How occurred:
Describe type of injury:

3 Information About Other Income

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

☐ Sick pay/Salary continuance ☐ State Disability ☐ Worker's Compensation
☐ Other:

4 Physician Information

Indicate physicians you are seeing or have seen for this condition.

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

5 Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Employee's signature X	Date signed

Sun Life Assurance Company of Canada
Short Term Disability Claim Packet

Attending Physician's Statement

Group STD policy number

1 Information About the Patient

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

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

Tel.: 800-247-6875
Fax: 781-304-5599

www.sunlife.com/us

Name of patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)	
Name of employer (parent company name)			
Patient home street address	City	State	Zip code
Patient home phone number	Patient work phone number		

2 Physician Information

- Complete all sections – any missing information may result in a delay to your patient
- Print clearly
- Fax this form to 781-304-5599 or as instructed by patient

Name of attending physician (first, middle initial, last)	Specialty	Tax ID#	
Street address	City	State	Zip code
Phone number	Fax number		

List other physicians treating for this condition

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

3 Diagnosis and History

Your response is required and affects the patient's benefit. Failure to complete this information may cause the patient financial hardship due to lack of benefit payments.

Primary Diagnosis (include any complications)	ICD-9 Code
Secondary Diagnosis (if applicable)	ICD-9 Code
Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, date occurred:	
If pregnancy, provide the following: Expected delivery date: Actual delivery date:	Delivery type: ☐ Normal ☐ C-Section
List any complications pre or post delivery that would extend this disability longer than a normal pregnancy.	
Is condition due to injury/sickness arising out of patient's employment? ☐ Yes ☐ No .....☐ Unknown	

Describe objective or abnormal findings and date.

If you need more room, check here ☐ and attach a separate sheet.

☐ X-ray ☐ EKG ☐ MRI ☐ PFT ☐ Ultrasound ☐ Other data (e.g. Labs)
Date(s):
Findings:

4 Treatment Details

Start date of disability	Date of first office visit	Date of last office visit	Date of next office visit

Was Emergency Room care required for condition? ☐ Yes ☐ No

Name of hospital	Date	Phone number

Check all that apply and describe type, frequency and treatment

☐ Surgery ☐ Medications prescribed ☐ Therapy ☐ Behavioral intervention ☐ Other

Date(s):

Procedure/Treatment:

Is patient: ☐ Hospital confined ☐ House confined Date from: ☐ Bed confined Date to: ☐ Ambulatory

Hospital name: Phone:

5 Restrictions and Limitations

Describe what the patient **can do.**	From: To:
Describe what the patient **should not do.**	From: To:

Is patient capable of working with these restrictions/limitations? ☐ Yes ☐ No

☐ Full-Time: 8+ hours/day ☐ Part-Time: _____ hours/day

Indicate class of impairment - As defined in federal dictionary of occupation titles

Physical Impairment

☐ Class 1 – No limitation
☐ Class 2 – Slight limitation
☐ Class 3 – Medium limitation
☐ Class 4 – Moderate limitation
☐ Class 5 – Severe limitation

Mental Impairment (if applicable)	**Current DSM-IV-R diagnosis**
☐ Class 1 – No limitation	Axis I:
☐ Class 2 – Slight limitation	Axis II:
☐ Class 3 – Moderate limitation	Axis III:
☐ Class 4 – Marked limitation	Axis IV:
☐ Class 5 – Severe limitation	Axis V:

Do you believe this patient is competent to endorse/direct the use of proceeds? ☐ Yes ☐ No

6 Return-to-Work

Indicate the specific date or recovery period for when the patient will recover sufficiently to perform duties.

- Return to patient's occupation full-time: Date: _____ **-or-**

  ☐ 1-2 wks ☐ 2-3 wks ☐ 3-4 wks ☐ 4-5 wks ☐ 5-6 wks ☐ 6-7 wks ☐ 7-8 wks
  ☐ 2 months or more ☐ Other: _____ ☐ Never

- Return to patient's occupation part-time: Date: _____ **-or-**

  ☐ 1-2 wks ☐ 2-3 wks ☐ 3-4 wks ☐ 4-5 wks ☐ 5-6 wks ☐ 6-7 wks ☐ 7-8 wks
  ☐ 2 months or more ☐ Other: _____ ☐ Never

7 Certification and Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Attending Physician Signature (original signature required) X	Date

Fraud Warnings

State law requires that we notify you of the following:

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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—District of Columbia: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—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.

Fraud warning—IN, ID, and DE: 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.

Fraud Warnings continued

Fraud warning—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.

Fraud warning—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 may be a crime and subjects such person to criminal and civil penalties.

Fraud warning—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.

Fraud warning—ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Fraud warning—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.

Fraud warning—NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud warning—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**.**

Fraud warning—OK: 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.

Fraud warning—OR: 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.

Fraud warning—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 with the penalty of 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 are 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.

Fraud warning—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.

Sun Life Assurance Company of Canada

Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authori-zations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:

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

Fax: 781-304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf to disclose my entire medical record and
any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records relating to my physical or mental condition, such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Short Term Disability Claims, SC4312, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number 224991
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
(800) 247-6875

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("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. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-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 and
- 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, and
- comply with federal, state or local laws, respond to a subpoena or comply with an injury 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, and
- 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 Assurance Company of Canada
Group Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481