Sun Life Insurance and Annuity Company of New York
Long Term Disability Claim Packet - Employer

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

Instructions for the Plan Administrator

Please call our Customer Service Center at 1-800-247-6875 from 8 a.m. to 8 p.m. Eastern Time to report any scheduled or actual return-to-work dates as soon as possible.

Please make sure that the employee initiates the Long Term Disability claim filing process as soon as it first appears that his or her disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

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

The Employer must:

☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.

☐ Attach copies of employee's medical information relating to the disability (if available).

☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.

☐ Attach a copy of all payroll documentation and attendance records for the last six months.

☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

NOTE:

FOR TRANSITION CLAIMS: If claimant is transitioning from a Sun Life Insurance and Annuity Company of New York Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes on page 3. Then complete the rest of the Employer portion of this claim packet.

FOR NON-TRANSITION CLAIMS: Fill out the entire Employer portion of this packet.

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 - Employer

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

Employer's Statement

1 General Information

Please print clearly.

If claimant is transitioning from a Sun Life Insurance and Annuity Company of New York Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Return to:
Sun Life Insurance
and Annuity Company
of New York
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Name of employer		Group policy number	Class
Street address	City	State	Zip
Name and address of division where employee works (if different from above)			

Does your company have a formal Return to Work Program? ..... ☐ Yes ☐ No

Contact Person	Telephone number

2 Employee Information

If claimant is transitioning from a Sun Life Insurance and Annuity Company of New York Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Name of employee (first, middle initial, last)			☐ M ☐ F
Social Security number	Date of birth (m/d/y)	Telephone number	
Employee's street address	City	State	Zip Code

3 Employment and Claim Information

If claimant is transitioning from a Sun Life Insurance and Annuity Company of New York Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Date hired (m/d/y)	Effective date of coverage	Date last worked (m/d/y)	Hours worked last day
What was the employee's permanent occupation on his/her last date of work?			
How long had employee been in occupation? Years: Months:		Regularly scheduled work week: Days per week: Hours per day:	
Has the employee's employment been terminated? ☐ Yes ☐ No		If yes, provide termination date	
Why did employee cease working?			
Is the condition due to an injury or sickness arising out of employee's job? ☐ Yes ☐ No ☐ Disputed			

Has a Workers' Compensation claim been filed? ..... ☐ Yes ☐ No
If "yes," please include the initial report of illness/injury and award/denial notice with this claim.

Name and address of your Workers' Compensation carrier:		Telephone number
Was employee covered under prior LTD policy? ..... ☐ Yes ☐ No	Effective date under prior policy (m/d/y)	Termination date under prior policy (m/d/y)
Has employee returned to work? ☐ Yes ☐ No If yes: ☐ With restrictions ☐ Full capacity		Date returned (m/d/y)

Continued on next page

4 Salary and Benefits Information – Complete this section for **all** claimants.

Please note that additional financial information may be required depending on your specific policy.

Please provide 6 months of payroll records prior to date last worked. Be sure to include documentation of hours worked, payments, contributions to LTD, and attendance records.

How was the employee paid? (check one)

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

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

Enrollment form is required if coverage is contributory.

Does employee contribute toward the LTD premium?..... ☐ Yes ☐ No

- If "yes," attach a copy of employee's enrollment form to this claim and indicate percentage contribution.....

Employee: %	Employer: %

- Are employee contributions made with pre-tax dollars?..... ☐ Yes ☐ No

5 Other Income Information – Complete this section for **all** claimants.

Check all that apply and provide details for each source of income.

Is employee currently receiving, or entitled to receive, benefits from any of the following sources?

	Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐	Sick Pay	$	☐ Wkly ☐ Mthly	
☐	Salary Continuance	$	☐ Wkly ☐ Mthly	
☐	State Disability	$	☐ Wkly ☐ Mthly	
☐	Workers' Compensation	$	☐ Wkly ☐ Mthly	
☐	Unemployment Compensation	$	☐ Wkly ☐ Mthly	
☐	Social Security Disability/Retirement	$	☐ Wkly ☐ Mthly	
☐	Disability/Retirement Pension	$	☐ Wkly ☐ Mthly	
☐	Automobile No-fault Insurance	$	☐ Wkly ☐ Mthly	
☐	Union Disability	$	☐ Wkly ☐ Mthly	
☐	Severance	$	☐ Wkly ☐ Mthly	
☐	Other:	$	☐ Wkly ☐ Mthly	

6 Employee's Occupation Information – Complete this section for **all** claimants.

Required: Please submit a copy of the employee's formal job description.

Job title / Major job duties (attach employee's formal job description)

7 Physical Aspects of Occupation – Complete this section for **all** claimants.

Please note that additional occupational information may be required.

In a typical work day, give the number of hours the employee spends in each of these positions and if employee may alternate positions.

Position	Total Number of Hours	May Alternate Positions: At Will	15-30 Mins.	Hourly	Never
Sitting		☐	☐	☐	☐
Standing		☐	☐	☐	☐
Walking		☐	☐	☐	☐
Driving		☐	☐	☐	☐

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7 Physical Aspects of Occupation continued – Complete this section for **all** claimants.

In a typical work day, the employee must:

	Occasionally (1/4 – 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)	Never
Bend/Stoop	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Crawl/Crouch	☐	☐	☐	☐
Lift _____ lbs.	☐	☐	☐	☐
Carry _____ lbs.	☐	☐	☐	☐

Does the employee use feet for repetitive movements, as in operating foot controls?
Right foot ☐ Yes ☐ No Left foot ☐ Yes ☐ No Both feet ☐ Yes ☐ No

What are the major tasks requiring use of one or both hands?

Check all that apply.

Which of the following describes the employee's working environment?
☐ Working at heights ☐ Exposure to dust, fumes and gases
☐ Operating heavy machinery ☐ Changes in temperature or humidity
☐ Precise manual dexterity ☐ Other hazards (specify): _____

8 Non-Physical Aspects of Occupation – Complete this section for **all** claimants.

Does employee have to answer customer complaints? ☐ Yes ☐ No
Is employee primarily evaluated on production? ☐ Yes ☐ No
Is employee routinely subject to close supervision? ☐ Yes ☐ No
Does employee work closely with his/her co-workers? ☐ Yes ☐ No
Is employee responsible for the overall performance of his/her particular department? ☐ Yes ☐ No
Number of people this employee supervises _____

9 Checklist of Required Attachments – Complete this section for **all** claimants.

Failure to provide the following information could result in a delay of the initial benefit payment.

☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.
☐ Attach copies of employee's medical information relating to the disability (if available).
☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.
☐ Attach a copy of all payroll documentation and attendance records for the last six months.
☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

10 Certification and Signature – Complete this section for **all** claimants.

Tip: To certify eligibility, mail or fax the employee's enrollment form with the claim.

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 person completing this form	Telephone number: Fax Number:
Title	E-mail address: Company's Website:
Signature X	Date signed

For more information about Long Term Disability, the claim process and the status of your employees' claims, log onto CustomerLink at https://customerlink.sunlife-usa.com

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