Disabled Child Coverage

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 To be completed by employer

This form should be used for a member's disabled child who exceeds the age of "child" specified in the group contract.

Your plan sponsor/employer	Location/billing group number

Member's last name	First name	Member ID number

Does member currently have dependent coverage? ☐ No ☐ Yes	If yes, dependent coverage became effective on: Date (yyyy-mm-dd) _ _

Coverage requested for disabled child:

☐ Extended Health Care Coverage	☐ Dental Care Coverage	☐ Dependant Child Life	☐ Dependant Critical Illness
Contract number	Contract number	Contract number	Contract number

Authorized signature	Daytime phone number	Date (yyyy-mm-dd)
X	_ _	_ _

2 To be completed by member

Disabled child's last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)
			_ _

Nature of disability	Date disability began (yyyy-mm-dd)
	_ _

Is your disabled child living with you and wholly dependent on you for support? ☐ **Yes** ☐ **No**

Has a disability tax credit certificate been sent to and approved by the Canada Revenue Agency for income tax purposes for this disabled dependent?

☐ **Yes** **If yes, please sign and return this application with a copy of any approval document issued by the Canada Revenue Agency.**

☐ **No** **If no, continue to Section 4.**

3 Member's authorization and signature

I certify that I am legally authorized to provide this authorization and certification. This is to certify that the above named unmarried child is 21 years of age or over and due to a disability became incapable of engaging in self-sustaining employment prior to age 21 or between the ages of 21 and 25 (or the age stipulated in any applicable legislation) while a full-time student at an accredited school, college or university, and is primarily dependent upon me for support and maintenance. The information I have given in this form is true and complete.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan, with the dependent's doctor, or any person or organization who has relevant information pertaining to this request for coverage including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

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

3 Member's authorization and signature (continued)

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. 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.

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.

Questions? Please visit **www.sunlife.ca** or call our toll-free number 1-800-361-6212
Monday - Friday, 8 a.m. - 8 p.m. ET

4 To be completed by attending physician

Diagnosis of patient's present condition

Restrictions or limitations in performing tasks such as heavy lifting, driving, operating machinery, sitting for prolonged periods.

Restrictions – the task cannot be performed.

Limitations – the tasks can be performed but not recommended.

Type and frequency of medication/treatment prescribed

Assistive devices

Assistive devices are aids that we determine could be used to improve the insured person's functioning. Assistive devices include but are not limited to adjustable beds, buttonhooks, canes, crutches, grab bars, handheld showerheads, bath brushes, seat lifts, transfer benches, walkers and wheelchairs.

Date child became incapable of self-support (yyyy-mm-dd)	Expected date when patient will be able to enter the workforce or re-attend school (yyyy-mm-dd)
Date last attended school (year) (yyyy-mm-dd)	Level of education attained

4 To be completed by attending physician (continued)

Patient's present condition
Check only those that the patient is incapable of performing

☐ **Bathing**
Bathing means washing oneself, with or without the aid of assistive devices:
- in a bathtub or shower, including getting in and out of the bathtub or shower, or
- by sponge bath.

☐ **Dressing**
Dressing means putting on, taking off, fastening and unfastening, with or without the aid of assistive devices:
- clothing, and
- medically necessary braces or artificial limbs.

An insured person is not dependent for dressing if reasonable alterations to or changes in the clothing they usually wear would enable them to dress without substantial physical assistance.

☐ **Feeding**
Feeding means the insured person's ability to get food into their body with or without the aid of assistive devices:
- through the mouth, or
- by a feeding tube.

Feeding does not include cooking or preparing a meal.

☐ **Toileting**
Toileting means getting to and from and on and off the toilet, with or without the aid of assistive devices, and performing associated personal hygiene.

☐ **Transferring**
Transferring means moving into or out of a bed, chair or wheelchair, with or without the aid of assistive devices.

This does not include getting into or out of the bathtub or shower, as we include this in bathing.

☐ **Continence**
Continence means the ability to control both bowel and bladder functions, or maintain a reasonable level of personal hygiene (including caring for catheter or colostomy bag) when not able to control either bowel or bladder functions or both.

Comments

Physician's last name	First name		
Phone number – –	Address (street number and name)		
Apartment or suite	City	Province	Postal code
Attending physician's signature X			Date (yyyy-mm-dd) – –

5 Mailing instructions

Mail your completed form to the claims office nearest you.

Toll-free fax number: 1-877-897-5519
Sun Life Assurance Company of Canada
Medical Underwriting
Private and Confidential
PO Box 11691 Stn CV
Montreal QC H3C 3J9

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