Tuition Expenses – Attending Physician's Statement

Sun Life Financial

Instructions to the Student:

- Please complete, sign and date Section 1.
- Ask your physician to complete Section 2.

Please note that you are responsible for the cost of completing this form.

Instructions to the Physician:

- Please complete, sign and date Section 2.
- Please enclose copies of chart notes, consult notes, investigations and test results that relate to your patient's claim for reimbursement of tuition and related expenses as a result of disability*.

Please PRINT clearly.

1 Student information

(This part of the form should be completed before the physician completes section 2)

Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or send a written request by e-mail to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.

Student last name	Middle initial	First name	☐ Male ☐ Female
Policy number(s)		Student ID number	
Date of birth (dd-mm-yyyy) – –	Height (cm)	Weight (kg)	

Patient's Authorization

I authorize my doctor to use and exchange information with Sun Life Assurance Company of Canada*, its agents and service providers and reinsurers for the purposes of underwriting, administration and paying claims under this insurance coverage with any person or organization who has relevant information about me including health professionals, government agencies, institutions, investigative agencies, insurers, and reinsurers.

Student's signature	Date (dd-mm-yyyy)
X	– –

*Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

For SLF use:
DC-203

2 Physician's report

Sun Life Assurance Company of Canada will use the information in this form to determine your patient's eligibility for reimbursement of tuition and related expenses as a result of disability.

We ask that you complete the Attending Physician's Statement as thoroughly as possible.

Please be assured that this information, including any medical records submitted in support of this tuition claim, will be treated confidentially.

Any information provided by you to Sun Life Assurance Company of Canada regarding this tuition claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.

Diagnosis

Primary
Secondary

A. Mental/Nervous impairment (if applicable)

1. What symptoms is this patient displaying that indicate a mental impairment exists?

2. Has there been a psychiatric referral? ☐ No ☐ Yes If Yes, Name of Psychiatrist

3. What is the diagnos(es) using the DSM IV?

Axis I
Axis II
Axis III
Axis IV
Axis V
Remarks

B. Investigations

Describe the results of any examinations, laboratory tests, X-rays, ECGs, and all other investigations related to the patient's disability. Please include copies of test results and reports.

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2 Physician's report (continued)

C. History

1. What was the date of the patient's first appointment for the claimed disability? Date (dd-mm-yyyy) _ _
2. What was the date of the patient's latest appointment? Date (dd-mm-yyyy) _ _
3. How often are the patient's appointments?
   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other Please specify
4. Did you recommend that patient stop attending all classes? ☐ No ☐ Yes
   As of what date? Date (dd-mm-yyyy) _ _

D. Treatment

1. Was the patient hospitalized? ☐ No ☐ Yes From Date (dd-mm-yyyy) _ _ To Date (dd-mm-yyyy) _ _
2. Was surgery performed? ☐ No ☐ Yes If yes, give details.

Date (mm-yyyy)	Type of surgery
_	
_	

3. If medication is being administered, please describe below:

Medication	Dosage	Date started (dd-mm-yyyy)	Date stopped (dd-mm-yyyy)	Response
		_ _	_ _	
		_ _	_ _	

4. What other treatments were given?

5. What further treatment is being considered?

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2 Physician's report (continued)

E. Progress

6. Which of the following best describes the progress of the student's condition since the patient stopped attending all classes?

☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

F. Limitations

7. How is your patient limited from attending all classes? What prevents a return to College or University?

G. Prognosis

8. What is your patient's expected date of return to class? Date (dd-mm-yyyy) _ _

H. Remarks

I. Physician information

Last name	First name	Specialty
Address (street number and name)		Apartment or suite
City	Province	Postal code
Telephone _ _	Fax _ _	

J. Physician's signature

Signature	Date (dd-mm-yyyy)
X	_ _

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