Plan Sponsor's Statement
Claim for Short-Term Disability benefits

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.

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1 Plan Member information

Sun Life Assurance Company of Canada must receive the Plan Member's Statement, Attending Physician's Statement and this form in order to review this claim. Please complete this form in its entirety in order to avoid delays.

First name	Last name (Quebec residents – maiden name)	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
			– –

Address (street number and name)	Apartment or suite

City	Province	Postal code

Home telephone number	Alternate telephone number
– –	– –

Regular occupation title/Job name

2 Plan Sponsor information

Please also submit the form, Disability Job Demands Questionnaire if the member is expected to be absent for 4 weeks or more.

Contract number	Class	Member ID	Division/Billing group number
102102	☐ C – Unionized employees TCRC ☐ C1 – Unionized employees UNIFOR #1 ☐ C2 – Unionized employees UNIFOR #2 ☐ C3 – Unionized employees UNIFOR #3 ☐ C4 – Unionized employees TCRC MWED		**200**

Company name
Via Rail Canada Inc.

Address (street number and name)
3 Place Ville Marie, Suite 500

City	Province	Postal code
Montreal	**QC**	**H3B 2C9**

Supervisor's name

Supervisor's telephone number	Ext.	Supervisor's email address
– –		

3 Employment information

This section asks for information on the member's employment and coverage status. This part should be completed by the person most familiar with these topics (for example, the Payroll Administrator or the Plan Administrator).

Does the employee work in a position that is ☐ safety critical or ☐ safety sensitive?

Date member started with the company (dd-mm-yyyy)	Last date of full-time duties/hours (dd-mm-yyyy)	Last date of modified work (if applicable) (dd-mm-yyyy)
– –	– –	– –

Was the member's employment terminated? ☐ No ☐ Yes If *yes*, on what date? Date (dd-mm-yyyy) – –

To the best of your knowledge, why did the member stop working?

3 Employment information (continued)

Date member returned to full-time duties (dd-mm-yyyy)	Date member returned to modified work (dd-mm-yyyy)
– –	– –
If applicable, please describe modifications	

Employment class (check one box in each row)

a) ☐ Full-time ☐ Part-time How many hours per week? _____
b) ☐ Permanent ☐ Contract ☐ Temporary ☐ Seasonal
c) ☐ Hourly ☐ Salaried ☐ Commissioned
d) ☐ Union
e) ☐ Spareboard

Is the member involved in shift work? ☐ No ☐ Yes If *yes*, provide details of the actual rotation schedule for the three months prior to the disability date and the planned schedule for the claimed disability period.

4 Coverage information

Date member's Short-Term Disability coverage became effective with Sun Life Assurance Company of Canada (dd-mm-yyyy)	Date member's Long-Term Disability coverage became effective with Sun Life Assurance Company of Canada (dd-mm-yyyy)
– –	– –

Was the member's coverage in force on the last day worked? ☐ Yes ☐ No If *no*, please provide date and reason (e.g. layoffs)

5 Earnings and benefit information

Member's regular salary at the last date worked

$ _____ per week

Date this salary became effective (dd-mm-yyyy)	Last day member's salary was paid (dd-mm-yyyy)
– –	– –

1. Is the plan under which this member is covered taxable? ☐ No ☒ Yes
2. Did the member have any scheduled vacation days after the last day worked? ☐ No ☐ Yes
   If *yes*, indicate the scheduled days. _____
3. What income, if any, does the member receive from you during the absence? Please provide dates and amounts.

How long will this income continue?

What income, if any, does the member receive (or will receive) during the course of this claim from your retirement or pension plan?

5 Earnings and benefit information (continued)

4. Is the member entitled to any other benefits from any other source (e.g. WCB/WSIB/CSST/CPP/QPP)?
☐ No ☐ Yes If *yes*, please describe.

From what date? Date (dd-mm-yyyy) – –

5. If the disability is due to pregnancy, has or will the member receive any maternity leave? ☐ No ☐ Yes

Date maternity leave begins Date (dd-mm-yyyy) – –

Date maternity leave ends Date (dd-mm-yyyy) – –

6. Are modified duties available? ☐ No ☐ Yes

Were modified duties offered? ☐ No ☐ Yes If *yes*, please describe duties (part-time/full-time/modified).

Did the member accept modified duties if offered? ☐ Yes ☐ No If *no*, please provide details below.

6 Declaration

I certify that the statements in this form are true and complete.

Last name of person signing this statement (please print)	First name	Position

Authorized signature	Date (dd-mm-yyyy)
X	– –

Telephone number	Fax number
– –	– –

To ensure prompt submission, please fax this form, along with any other information in support of the plan member's claim, to the Sun Life Assurance Company of Canada Group Disability Management Office listed below. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the appropriate address.

Montreal:
Fax: 1-866-639-7846
Email: *GroupDisabilityClaimsSubmission@sunlife.com*
PO Box 11037 Stn CV
Montreal QC H3C 4W8