Sun Life Assurance Company of Canada

Long-Term Disability – Employer Statement

1 Employer information

Employer's name Bronson Healthcare Group, Inc.	SSN/TIN	Telephone number	Fax number
Address 601 John Street	City Kalamazoo	State MI	Zip code 49007

2 Employee information

Employee's name	Date of birth (m/d/y)	SSN

Address	City	State	Zip code

3 Employment and claim information

Location/branch where Employee works	Policy number 901802	Employee's date of hire (m/d/y)
Location/branch telephone number	LTD effective date of policy (m/d/y)	Employee's class: ☐ Class 1 ☐ Class 2
Was employee covered under prior LTD policy? ☐ Yes ☐ No	Prior policy effective date (m/d/y)	Prior policy termination date (m/d/y)

Date Employee last worked (m/d/y)	Date Employee returned to work (m/d/y)	☐ Full-time ☐ Part-time

Work schedule at time last worked:	Number of days per week:	Hours per day:

Reason for stopping work?			Is condition due to occupational cause?	If "yes", please indicate status of Workers' Compensation claim	
☐ Accident	☐ Sickness	☐ Resigned	☐ Yes	☐ Accepted	☐ Denied
☐ Retired	☐ Granted LOA	☐ Vacation	☐ No	☐ Pending	☐ Not filed
☐ Terminated	☐ Laid off	☐ Other	☐ Undetermined		

☐ If applicable, check here to confirm you are attaching a copy of Workers' Compensation Claim and Approval/Denial Notification.

4 Salary and benefits information

Please note that additional financial information may be required. An Enrollment form is required if coverage is contributory. Please provide 3 months of payroll records prior to the date last worked. Be sure to include documentation of hours worked, payments, contributions to LTD and attendance records.

How was employee paid?	☐ Salary	☐ Hourly	☐ Salary & Commissions	☐ Bonuses	☐ Commissions only

Earnings frequency: ☐ Bi-weekly ☐ Monthly ☐ Weekly ☐ Semi-monthly	Earnings (excluding commissions and bonuses) $
LTD Premium contribution	Employer pays: 100%

5 Description and physical aspects of occupation

Occupation	Percentage of day spent:		Lifting requirements:	
Job description (attach separate file if necessary)	Sitting	%	Max lbs.	
	Standing	%		
	Walking	%	Min lbs.	
	Total (must = 100%)	%		

6 Other income information

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

Source of income (check all that apply)	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐ Sick Pay	$	☐ Wkly ☐ Mthly	
☐ Salary Continuance	$	☐ Wkly ☐ Mthly	
☐ Wages, Salary or Holiday Pay	$	☐ Wkly ☐ Mthly	
☐ Vacation Pay	$	☐ 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	
☐ LTD, STD Benefits	$	☐ Wkly ☐ Mthly	
☐ Other:	$	☐ Wkly ☐ Mthly	

7 Workers' Compensation information

Worker's Compensation Carrier	Workers Compensation contact	Telephone number	
Address	City	State	Zip code

8 Certification and signature

Fraud warning: 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.

I certify that the above statements are true and complete. I have read or had read to me the fraud warning.

Name of person completing this form*	Title	Date signed (m/d/y)

Contact information:

Telephone number: E-mail address:

Fax number: Company's website:

☐ **I verify that the typed name above is my electronic signature***

Contact us

By mail
Sun Life Assurance Company of Canada
Group Long-Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481

By fax
781-304-5537

By e-mail
MyClaimDocuments@sunlife.com

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET

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