

Sun Life and Health Insurance Company (U.S.)

Long-Term Disability Activities of Daily Living Questionnaire



The purpose of this form is to gather information about the Claimant's current condition so we can assess eligibility for benefits.

1 Claimant Information

Patient's name	Date of birth (mm/dd/yyyy)	Claim number	
Patient's address			
City	State	Zip code	Telephone number

1 Attending Physician Information

Attending physician's name	Degree/Specialty	Tax ID number		
Attending physician's address				
City	State	Zip code	Telephone number	Fax number

2 Activities of Daily Living

Check the box below that best describes the patient's current level of ability to safely and completely perform the following activities of daily living without another person's assistance or verbal cueing. **Please check only one box per activity.**

Use the following definition of each activity of daily living to complete this section:

- **Bathing:** the ability to wash, either in the tub or shower or by sponge bath, with or without equipment or adaptive devices.
- **Dressing:** the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- **Toileting:** the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- **Continence:** the ability to either; 1) voluntarily control bowel and bladder function; or 2) if incontinent, be able to maintain a reasonable level of personal hygiene.
- **Eating:** the ability to get nourishment into the body.

Activity of daily living	No assistance needed	Stand-by assistance needed	Physical hands-on assistance needed	Date assistance first needed (mm/dd/yyyy)	Expected duration
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Additional information about the patient's ability to perform activities of daily living:

3 Cognitive Impairment

Please use the following definition of cognitive impairment to complete this section:

Cognitive impairment: An individual has a deterioration or loss in intellectual capacity resulting from injury, sickness, advance age or Alzheimer’s disease and similar forms of irreversible dementia and the individual needs another person’s assistance or verbal cuing for the individual’s protection or for the protection of others.

1. Has any form of cognitive impairment been diagnosed? Yes No

Date of onset (mm/dd/yyyy) Expected duration

If you answered “Yes” above, please attach clinical findings, including testing results, to support your conclusion.

2. Please check the box that best describe the patient’s level of cognitive impairment:

- Patient **does not** have cognitive impairment as described above
- Patient has **mild** cognitive impairment that does not require continual supervision
- Patient has **severe** cognitive impairment and requires continual supervision (including cueing) for protection from health and safety threats.

3 Signature(s)

I certify that the above statements are true and complete.

Attending physician’s signature X	Date (mm/dd/yyyy)
Please PRINT name below	

Contact us

 **By mail**
Sun Life Financial
P.O. Box 81830
Wellesley Hills, MA 02481

 **By fax**
781-304-5537

 www.sunlife.com/us

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