

Sun Life Assurance Company of Canada

Customized Disability Claim – Employee Statement



Plan administrator instructions

Please make sure to initial the Disability claim filing process as soon as possible. Please refer to your group insurance policy to determine the length of the elimination period.

It is the responsibility of the employee to ensure that the Employee Statement, Employer Statement, and the Attending Physician Statement are submitted directly to Sun Life Financial.

The Employee must:

- Sign and date the Employee Statement
- Sign and date the Authorizations
- Have the employer complete and return the Employer Statement to Sun Life Financial
- Have the physician complete and return the Attending Physician Statement to Sun Life Financial

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

1 General information

Name of employee (first, middle initial, last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Group policy number	
Street address	City	State	Zip code	
Social Security number		Phone number		
Date of birth (mm/dd/yyyy)				
Occupation			Marital status	
Spouse's name (first, middle initial, last)	Social Security number	Date of birth (mm/dd/yyyy)		
Is your spouse employed				<input type="checkbox"/> Yes <input type="checkbox"/> No
Names and dates of birth of your children (under age 25)				

2 Information about the condition causing your disability

If a motor vehicle accident is the cause of your disability, you must submit a motor vehicle accident report along with this statement.

Date of accident or date you first noticed symptoms of your illness (mm/dd/yyyy)		
Describe in detail how, when and where the accident occurred –OR– Describe the nature of your illness/condition and its first symptoms.		
Is your condition due to injury or sickness related to your job?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain below.		
Date you were first treated by a physician (mm/dd/yyyy)	Last date worked prior to disability (mm/dd/yyyy)	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date first unable to work (mm/dd/yyyy)	Have you returned to work?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date: <input type="checkbox"/> With restrictions <input type="checkbox"/> Full capacity	
If work-related, have you filed or do you intend to file, a Workers' Compensation claim?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide date:		

3 Your treating physician(s) information

Name of physician		Specialty	
Street address		City	State Zip code
Telephone number	Fax number	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)
Have you discussed a return to work plan with this physician?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

Name of physician		Specialty	
Street address		City	State Zip code
Telephone number	Fax number	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)
Have you discussed a return to work plan with this physician?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If you need more space, check here <input type="checkbox"/> and attach a separate page.			

4 Hospital information

Name of hospital	Phone number	Dates of confinement (mm/dd/yyyy) to
Name of hospital	Phone number	Dates of confinement (mm/dd/yyyy) to

If you need more space, check here and attach a separate page.

5 Other income information

Check all that apply and provide award/denial notice or application associated with any source of income.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
Sick pay	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Salary continuance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
State disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Workers' compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Unemployment compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Social Security Disability/retirement	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Disability/retirement pension	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Automobile no-fault insurance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Union disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Severance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	
Other:	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	

6 Direct deposit information

Name of bank		Telephone number	
Street address	City	State	Zip code
Type of account <input type="checkbox"/> Checking <input type="checkbox"/> Savings		Account number	
Transit/routing number*		*Checking account – attach a voided check	

7 Fraud warnings

State law requires that we notify you of the following:

General fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, MA, MN, NM, RI, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DE, ID and IN: 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.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

7 Fraud warnings, continued

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR and VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

8 Certification and signature

Reminder: Please be sure to sign and return any Authorization statements included in this packet.

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

Employee's signature

X

Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada



Authorization for Release and Disclosure of Health Related Information

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Customized Disability Claims, Sun Life Financial, SC 4312, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date (mm/dd/yyyy)

Sun Life Assurance Company of Canada



Authorization for Release and Disclosure of Psychotherapy Notes

I HEREBY AUTHORIZE any: physician, healthcare provider, health plan, medical professional, hospital, clinic, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”), its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that the Company will use the information it obtains to: (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Group Customized Disability Claims, Sun Life Financial, SC 4312, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date (mm/dd/yyyy)

Authorization for Release and Disclosure of Non-Health Related Information

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., Social Security Administration, Internal Revenue Service or the Veteran’s Administration, to disclose to Sun Life Assurance Company of Canada (“the Company”), its subsidiaries, affiliates, third party administrators, and reinsurers, any and all non-health information relating to me, including, but not limited to (a) my employment earnings; (b) my occupational duties; (c) my credit history; (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I, or my dependents, may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize the Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim. I further authorize the Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Customized Disability Claims, Sun Life Financial, SC 4312, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print name of employee or personal representative of employee	Group policy number
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date (mm/dd/yyyy)

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada (“the Company”) collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application or to evaluate your claim. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, healthcare providers, medical professionals, hospitals, clinics or other medical or healthcare related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose

such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

Contact us



By mail

Sun Life Assurance Company
of Canada
Customized Disability Claims
P.O. Box 81915
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