Sun Life Assurance Company of Canada

Customized Disability Claim – Attending Physician Statement

Plan administrator instructions

The Attending Physician must:

☐ Complete, sign and date the Attending Physician Statement

☐ Submit the Attending Physician Statement directly 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 Patient information

The patient is responsible for any costs associated with the completion of this form.

Name of employee (first, middle initial, last)		☐ Male ☐ Female
Social Security number	Date of birth (mm/dd/yyyy)	Phone number

Do you believe this patient is competent to endorse checks?..... ☐ Yes ☐ No

Physical conditions only

Skip this section if claim is for behavioral condition.

2 Diagnosis and history information

Provide general information about diagnosis and history in this section. Then, please elaborate in sections 3 to 7, as appropriate.

If this claim is related to a normal pregnancy, please complete this pregnancy section only.
☐ Pregnancy

Date of first visit (mm/dd/yyyy)	When did symptoms first appear? (mm/dd/yyyy)	Date first treated (mm/dd/yyyy)
Expected delivery date (mm/dd/yyyy)	Actual delivery date (mm/dd/yyyy)	Delivery type ☐ Vaginal ☐ C-section
Date first unable to work (mm/dd/yyyy)	Dates hospitalized (mm/dd/yyyy) From: To:	
Describe all complications that requires early bed rest	Date best rest commenced (mm/dd/yyyy)	
Has patient been released to work in her **own** occupation..... ☐ Yes ☐ No		
Has patient been released to work in **any** occupation..... ☐ Yes ☐ No If "No," when should the patient be able to return to work? ..... ☐ Full-time ☐ Part-time		
Describe any complications that would extend this disability longer than a normal pregnancy.		

☐ Spotting*	☐ Placenta previa*
☐ Bleeding	☐ Incompetent cervix/cerclage
☐ Contractions requiring medications	☐ Hypertension
☐ Severe pre-eclampsia	☐ Twins
☐ Other	☐ Triplets

* Please submit ultrasounds and prenatal records with the Attending Physician Statement

List all medications prescribed	Blood pressure when disability commenced Rise above systolic: Rise above diastolic:

2 **Diagnosis and history information**, continued

☐ All other physical conditions

Diagnosis including any complications		
Objective findings/investigative testing (for example, X-rays, EKGs, MRIs, laboratory data, etc.)		
Subjective findings		
Date symptoms first appeared or date of accident (mm/dd/yyyy)	If injury due to a motor vehicle accident, indicate in which state the accident occurred.	
Date first unable to work (mm/dd/yyyy)	Dates hospitalized (mm/dd/yyyy) From: To:	
Patient's height:	Patient's weight:	Blood pressure:
Is condition due to injury/sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown		
Has patient been released to work in their **own** occupation ..... ☐ Yes ☐ No		
Has patient been released to work in **any** occupation ..... ☐ Yes ☐ No If "No," when should the patient be able to return to work? ..... ☐ Full-time ☐ Part-time		
Names and addresses of other treating physicians (if applicable)		

3 **Treatment information**

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Date of last examination (mm/dd/yyyy)
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☐ Other (please specify): _____		
Description of treatment		

4 **Progress**

Patient: ☐ Unchanged ☐ Improved ☐ Retrogressed ☐ Ambulatory ☐ Bed confined

If retrogressed, please explain:		
Has patient been hospital confined? ..... ☐ Yes ☐ No	From:	To:
If "yes," provide name of hospital		

5 Restrictions and limitations

Please note that additional occupational information may be required.

Patient is able to use hand for repetitive actions such as:

	Simple grasping	Firm grasping	Fine manipulation
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the patient has demonstrated a loss of function, please describe restrictions and limitations below.

Restrictions (what the patient should not do)

Limitations (what the patient cannot do)

Date restrictions and limitations began

Physical impairment

- ☐ No limitation of functional capacity - (no restrictions)
- ☐ Medium capacity - (lifting, carrying, pushing, pulling 20-50 lbs. occasionally; 10-25 lbs. frequently; or up to 10 lbs. constantly)
- ☐ Light capacity - (lifting, carrying, pushing, pulling 20 lbs. occasionally; 10 lbs. frequently; or negligible amount constantly. Can include walking and/or standing frequently even if the weight is negligible. Can include pushing or pulling of arm or leg controls.)
- ☐ Sedentary capacity **-** (lifting, carrying, pushing, pulling 10 lbs. occasionally. Mostly sitting, may involve standing or walking for brief periods of time.)
- ☐ Comments (please explain):

Cardiac (if applicable) – Functional capacity (American Heart Association)

☐ No limitation ☐ Marked limitation
☐ Slight limitation ☐ Complete limitation

6 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ Longer

7 Remarks

Complete this section for all claimants. It's required to submit a copy of the employee's formal job description.

Please use this space for any additional comments.

8 Certification and signature

Remember to provide your full address and tax ID number. A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud warning shown below that is applicable to my state.

Name of Attending Physician (first, middle initial, last)		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Phone number	Fax number	
Attending Physician signature X			Date

Contact us

By mail
Sun Life Assurance Company of Canada
P.O. Box 81915
Wellesley Hills, MA 02481

By fax
781-304-5599

www.sunlife.com/us

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

Behavioral health conditions only

2 Additional patient information

In order to evaluate a claim for Disability Benefits submitted by your patient, we need more detailed information about his/her medical condition. Please respond to the following questions.

Axis I	_____	DSM IV TR Code	_____
Axis II	_____	DSM IV TR Code	_____
Axis III	_____	No code	_____
Axis IV	_____	No code	_____
Axis V	_____		

GAF:	Current:	Baseline:	Highest in past year:

3 Treatment information

When did the patient first experience psychiatric symptoms?
What was the first date you treated the patient for symptoms?
Name of first treating physician for symptoms (first, middle initial, last)
Please list facilities and dates of any hospitalization, intensive outpatient program, or partial hospitalization program.
What was the diagnosis at that time?
Current diagnosis
Describe the patient's current psychiatric symptoms and mental status evaluation.
Is the patient's current condition related to chemical dependency? ☐ Yes ☐ No If "Yes," please describe
Has there been any psychological testing? ☐ Yes ☐ No If "Yes," and available, provide results. If not available, why? Are there any plans in the future to perform testing? ☐ Yes ☐ No
Please describe the treatment methods/treatment plan.
List medications with dosages. Please note any recent changes.
Please describe patient's response to treatment to date. (Include any past treatments and additional methods of treatment being considered.)
Please describe if the patient's psychiatric condition is limiting the patient's functional capacity.

4 Prognosis

How long will those limitations apply? (estimated)			
☐ 6 weeks	☐ 8 weeks	☐ 12 weeks	☐ Longer

5 Certification and signature

Remember to provide your full address and tax ID number. A stamp or signature of a person other than the examining physician is not acceptable.

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Name of Attending Physician (first, middle initial, last)		Degree/specialty	
Street address	City	State	Zip code
Tax ID number	Phone number	Fax number	
Attending Physician signature X			Date (mm/dd/yyyy)

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Fraud warnings

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Fraud warning—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.

Fraud warning—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.

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Fraud warning—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.

Fraud warning—IN, ID, and DE: 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.

Fraud warning—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.

Fraud warning—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 may be a crime and subjects such person to criminal and civil penalties.

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Fraud warning—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.

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

Fraud warnings

Fraud warning—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**.**

Fraud warning—OK: 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.

Fraud warning—OR: 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.

Fraud warning—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 with the penalty of 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 are 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.

Fraud warning—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.

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Sun Life Assurance Company of Canada

Customized Disability Claim – Employer Statement

Plan administrator instructions

Please make sure that the employee initiates the Disability claim filing process as soon as it first appears that his or her disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

Be sure to call our Customer Service Center to report any scheduled or actual return-to-work dates as soon as possible.

Submit the Employer's Statement directly to Sun Life Financial.

The Employer must:

☐ Attach a copy of the enrollment form if the employee contributes to the premium.

☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.

☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

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 employer		Group policy number	Class
Street address	City	State	Zip code
Name and address of division where employee works (if different from above)			

Does your company have a formal Return-to-Work program? ☐ Yes ☐ No	
Contact person	Phone number

2 Employee information

Name of employee (first, middle initial, last)			☐ Male ☐ Female
Street address	City	State	Zip code
Social Security number	Date of birth (mm/dd/yyyy)	Phone number	

3 Employment and claim information

Date hired (mm/dd/yyyy)	Effective date of change (mm/dd/yyyy)	Date last worked (mm/dd/yyyy)	Hours worked last day (mm/dd/yyyy)
What was the employee's permanent occupation on his/her last date of work?			
How long had the employee been in the occupation? Years: Months:		Regularly scheduled work week: Days per week: Hours per day:	
Has the employee's employment been terminated? ☐ Yes ☐ No If "Yes," provide the termination date (mm/dd/yyyy):			
When did the employee cease working?			
Is the condition due to an injury or sickness arising out of employee's job? ☐ Yes ☐ No ☐ Disputed			
Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," please include the initial report of illness/injury and award/denial notice with this claim.			
Name and address of your Workers' Compensation carrier:		Phone number	
Was employee covered under prior disability policy? ☐ Yes ☐ No			
Effective date under prior policy (mm/dd/yyyy)		Termination date under prior policy (mm/dd/yyyy)	
Has employee returned to work? ☐ Yes ☐ No If "Yes,": ☐ With restrictions ☐ Full capacity			Date returned (mm/dd/yyyy)

4 Salary and benefit information

Complete this section for all claimants. Please provide two months of payroll records prior to date last worked. Be sure to include documentation of hours worked, payments, contributions to plan, and attendance records.

Please note that additional financial information may be required depending on your specific policy.

How was the employee paid? (check one)	☐ Hourly: $ per hour	☐ Salaried: $ per week
Provide information about other income ☐ Commissions: $	☐ Bonuses: $	☐ Overtime: $

Enrollment form is required if coverage is contributory.

Does employee contribute toward the premium? ☐ Yes ☐ No If "yes," attach a copy of employee's enrollment form to this claim and indicate percentage contribution. Employee: % Employer: %
Are employee contributions made with pre-tax dollars? ☐ Yes ☐ No

5 Other income information

Complete this section for all claimants.

Is the employee currently receiving, or entitled to receive, benefits from any of the following sources?
Check all that apply and provide details for each source of income.

Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
Sick pay	$	☐ Wkly ☐ Mthly	
Salary continuance	$	☐ 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	
Other:	$	☐ Wkly ☐ Mthly	

6 Employee's occupation information

Complete this section for all claimants. It's required to submit a copy of the employee's formal job description.

Job title / major job duties (attach employee's formal job description)

7 Fraud warnings

State law requires that we notify you of the following:

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7 **Fraud warnings,** continued

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Fraud warning—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

Complete this section for all claimants. To certify eligibility, mail or fax the employee's enrollment form with the claim.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning shown above that is applicable to my state.

Name of person completing this form		
Title		
Phone number	Fax number	
E-mail address	Company's website	
Signature X		Date signed (mm/dd/yyyy)

For more information about the Disability claim process and the status of your employees' claims, log onto SunLife Connect at http://www.sunlifeconnect.com/slconnect/login/slclogin.cfm.

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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)	☐ Male ☐ 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 ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No
Date first unable to work (mm/dd/yyyy)	Have you returned to work? ☐ Yes ☐ No If "Yes," Date: ☐ With restrictions ☐ Full capacity	
If work-related, have you filed or do you intend to file, a Workers' Compensation claim? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No			

If you need more space, check here ☐ 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	$	☐ Wkly ☐ Mthly	
Salary continuance	$	☐ 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	
Other:	$	☐ Wkly ☐ Mthly	

6 Direct deposit information

Name of bank		Telephone number	
Street address	City	State	Zip code
Type of account ☐ Checking ☐ Savings		Account number	
Transit/routing number*	*Checking account – attach a voided check * Savings account – Contact bank/credit union for transit/routing number		

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Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

Fraud warning—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.

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

Fraud warning—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.

Fraud warning—IN, ID, and DE: 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.

Fraud warning—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.

Fraud warning—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 may be a crime and subjects such person to criminal and civil penalties.

Fraud warning—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.

Fraud warning—ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Fraud warning—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.

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

7 **Fraud warnings,** continued

Fraud warning—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**.**

Fraud warning—OK: 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.

Fraud warning—OR: 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.

Fraud warning—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 with the penalty of 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 are 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.

Fraud warning—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 and understand the Fraud Warning shown above that is applicable to 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)

Sun Life Assurance Company of Canada

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)

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
1-800-247-6875

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