Sun Life Assurance Company of Canada
Death Benefits Claim Packet

Instructions for the Plan Administrator

In the event of the death of an insured employee or dependent, please follow these steps as soon as you receive notice of death:

1. Complete the Employer's section of this claim packet and collect the following:
   - ☐ a copy of any and all enrollment forms
   - ☐ a copy of beneficiary designation on file
   - ☐ an original certified death certificate – must include the final cause and manner of death
   - ☐ the most recent payroll record for one full pay period prior to the employee's last day

2. Provide the beneficiary with the Claimant's section of this claim packet. Instruct him or her to complete and sign the form and return it to the Employer along with the original certified death certificate.

3. If this is an Accidental Death, please have the Employer or Beneficiary submit:
   - ☐ an original police report
   - ☐ an original autopsy report
   - ☐ an original toxicology report

   If there is no autopsy or toxicology report done, please send verification from the coroner, medical examiner or admitting hospital.

4. **Collect all completed sections and additional required information and submit the entire packet to the address below.**

   Sun Life Financial
   Group Life Claims
   P.O. Box 81365
   Wellesley Hills, MA 02481
   Tel: 1-800-247-6875

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

Fraud Warnings

State law requires that we notify you of the following:

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.

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.

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—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 Warnings continued

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

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.

Sun Life Assurance Company of Canada
Death Benefits Claim Packet

Section A: Employer's Statement

1 General Information

Please print clearly.

Employer's name		Group policy number	Billing number
Employer contact (name of person completing this form)		Title	
Employer's street address	City	State	Zip Code
Employer's email address	Telephone number	Fax number	
Name and address of Division where Employee worked (if different from above)			

2 Employee Information

Employee's name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)	
Employee's street address	City	State	Zip Code

3 Dependent Information (Complete only if submitting a Dependent claim)

Dependent's name (first, middle initial, last) ☐ M ☐ F	Date of birth (m/d/y)	Relationship to employee

4 Employment and Claim Information

Complete entire section.

Date hired (m/d/y)	Effective date of insurance	Scheduled hours	Occupation
Date last worked	Reason for last day worked		
Date premiums terminated (m/d/y)	Class (as defined by policy)		
Date of last qualifying status change ☐ Part-time to Full-time ☐ Marriage ☐ Birth of a child			

Type of Claim (check all that apply)	Date of Death (m/d/y)	Basic	Optional
☐ **Life**		**$**	**$**
☐ **Dependent**		**$**	**$**
☐ **Accidental Death**		**$**	**$**

5 Salary and Benefits Information

How was the deceased paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per year:

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

What was the date of the last pay increase?

Did you apply age reductions on the amount of insurance ..... ☐ Yes ☐ No

6 Certification and Signature

Tip: To certify eligibility, submit the Employee's enrollment form with the claim.

I certify that the above statements are true and complete.

Signature of Administrator	Date signed
X	

Sun Life Assurance Company of Canada
Death Benefits Claim Packet

Section B: Claimant's Statement

Instructions

Return this completed form to the employer along with a certified copy of the Official Death Certificate.

Complete this form if benefits are legally payable to you as a beneficiary. You are a beneficiary if the insured designated you on his or her most recently dated enrollment or beneficiary designation form. When there is more than one beneficiary, each beneficiary must complete a separate form.

Please see page 8 for additional instructions if:

- The beneficiary is the estate of the insured
- The beneficiary is a trust
- The beneficiary is a minor
- The insured's death has been ruled accidental

1 Information About the Deceased

Please print clearly.

Employer's name			Group policy number
Employee's name (first, middle initial, last) ☐ M ☐ F		Social Security number	Date of birth (m/d/y)
Deceased's name (first, middle initial, last) ☐ M ☐ F			Social Security number
Date of birth (m/d/y)		Relationship	

2 Information About the Beneficiary

For individuals, enter your Social Security number or IRS Individual Taxpayer Identification number. For other entities, enter Employer Identification Number.

Name of beneficiary (first, middle initial, last) or estate		Date of birth (m/d/y)	Relationship
Social Security number or Tax Identification number		Telephone number	
Address of beneficiary or estate	City	State	Zip code

I certify that the statements made in sections 1 and 2 above are true and complete

Signature of beneficiary or estate representative X	Date (m/d/y)

3 Information About the Accidental Death (only if applicable)

To be completed by the beneficiary.

1. Did the accidental death occur at least 100 miles from the employee's principal place of residence? ☐ Yes ☐ No
2. Did the accidental death occur while the employee was traveling on business for the employer? ☐ Yes ☐ No
3. Are there any children of the employee in the 12th grade or currently enrolled in an accredited post-secondary institution of higher learning? ☐ Yes ☐ No
4. Did any family member incur any bereavement counseling expenses? ☐ Yes ☐ No

4 Method of Payment

You may choose to receive the life insurance benefit in a lump sum check or by having it paid into a Sun Life Financial Benefit Account.

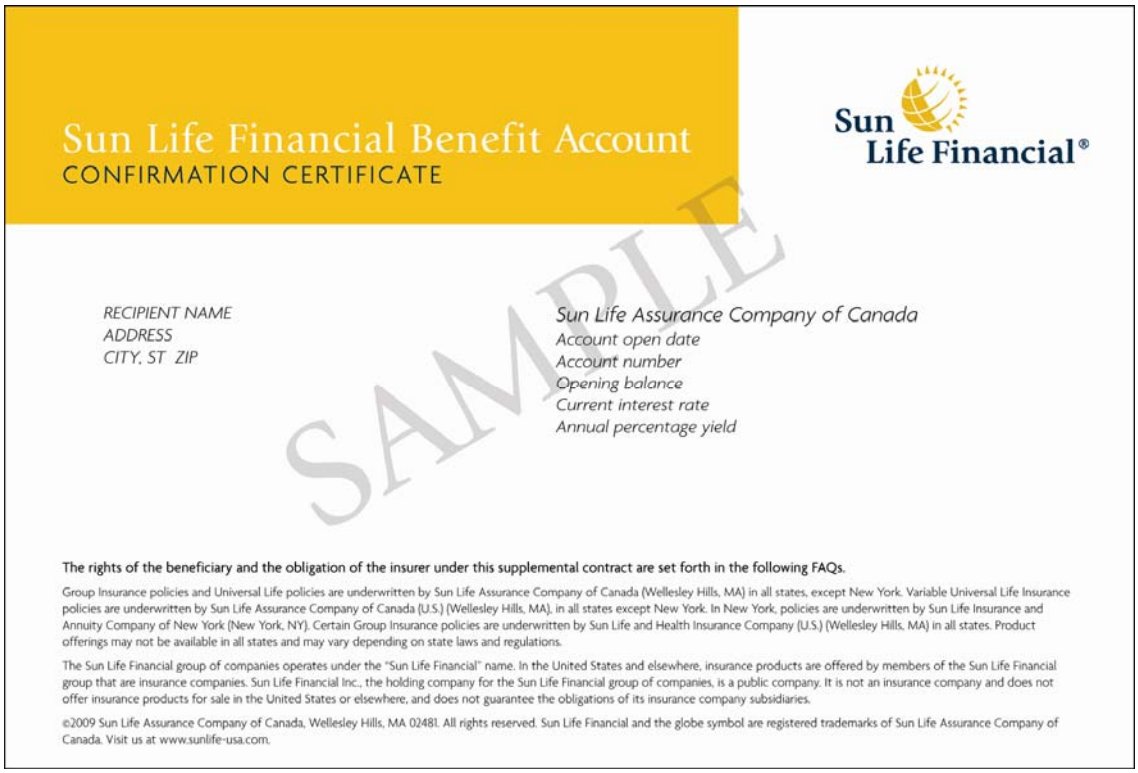
The Sun Life Financial Benefit Account is available to all individual beneficiaries who will receive a benefit of $10,000 or more. If the beneficiary is a corporation, trust, or a guardian of a minor, or the benefit is less than $10,000, the benefit will be paid by check.

If the beneficiary is a minor and no guardian of the minor's estate has been appointed, we will pay the benefit into a Sun Life Financial Benefit Account. The Sun Life Financial Benefit Account is immediately available to the guardian of the minor's estate once the guardian has been appointed and to the minor once he or she reaches the age of majority.

After you have read the "Sun Life Financial Benefit Account FAQs," please indicate your choice below. **If no selection is made, benefits will be paid by check. (For policies issued in and for residents of Kentucky, Maryland, New Hampshire, New Jersey, and Rhode Island, payment will be made by check.)**

☐ I elect a check

☐ I elect the Sun Life Financial Benefit Account



Sun Life Financial Benefit Account
CONFIRMATION CERTIFICATE

Sun Life Financial®

SAMPLE

RECIPIENT NAME
ADDRESS
CITY, ST ZIP

Sun Life Assurance Company of Canada
Account open date
Account number
Opening balance
Current interest rate
Annual percentage yield

The rights of the beneficiary and the obligation of the insurer under this supplemental contract are set forth in the following FAQs.

Group Insurance policies and Universal Life policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York. Variable Universal Life Insurance policies are underwritten by Sun Life Assurance Company of Canada (U.S.) (Wellesley Hills, MA), in all states except New York. In New York, policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY). Certain Group Insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Wellesley Hills, MA) in all states. Product offerings may not be available in all states and may vary depending on state laws and regulations.

The Sun Life Financial group of companies operates under the "Sun Life Financial" name. In the United States and elsewhere, insurance products are offered by members of the Sun Life Financial group that are insurance companies. Sun Life Financial Inc., the holding company for the Sun Life Financial group of companies, is a public company. It is not an insurance company and does not offer insurance products for sale in the United States or elsewhere, and does not guarantee the obligations of its insurance company subsidiaries.

Sun Life Financial Benefit Account: FAQs

The Sun Life Financial Benefit Account is an interest-bearing account established in your name. It is one of Sun Life Financial's methods of payment for life insurance benefit proceeds. The full amount of your life insurance proceeds is available to you at any time. If you elect the Sun Life Financial Benefit Account, any policy settlement options will not be available. You will receive either enclosed in this package, or separately, your own Sun Life Financial Benefit Account Confirmation certificate, which is the supplemental contract for this account, and a draft book, which is similar to a check book. We refer to drafts as checks in these materials. Drafts are similar to checks with some differences; for example, drafts may not credit your bank account as quickly as checks, and drafts may not be accepted by certain retailers.

You can access your proceeds immediately by writing a check. You will also receive monthly statements listing all checks written, the interest credited to your account, any interest rate changes, and any special services that have been requested. (See special fees below.)

This account, which is an obligation of the Sun Life Financial insurance company that issued the life insurance policy, is a secure place for these insurance proceeds.

Sun Life Financial Benefit Account: FAQs *continued*

Review these FAQs and keep this document with your files for future reference.

How does my account work?

You will soon receive a welcome package with a Sun Life Financial Benefit Account opening statement and a supply of checks. You may write a check for the full amount of your account balance at any time or keep all or some of these proceeds in the interest-bearing account. Checks drawn on your Sun Life Financial Benefit Account are payable through BNY Mellon.

How is interest determined and credited?

Interest is earned on proceeds in your Sun Life Financial Benefit Account from the date your account is established until the date checks are cleared. Interest is compounded daily and is credited to your account once a month. We determine the interest rate, at our sole discretion, and may change it periodically. There is no minimum interest rate. (The current rate may be found at http://www.sunlife.com/us/Service+center/How+do+I/Employee+benefits?vgnLocale=en_CA). Interest income is reflected in your monthly statement.

We may derive income, in addition to fees charged on the Sun Life Financial Benefit Account, from the investment of the balance of funds in the retained asset account.

Are there any special fees?

We provide you with your first set of checks and free checking services. You will be charged for any special services as follows:

- $15 for each stop payment order • $5 for requests for check copies
- $10 for insufficient funds • $25 for a check book rush request
- $2.35 for a check book reorder • $10 for statement copies

What if I have questions about my account?

Please call our Customer Service Center at 866-223-9149. You also can call this number to request any of the special services listed above.

Is there a minimum check amount?

The minimum amount for which a check may be written on your Sun Life Financial Benefit Account is $250.

Is there a limit on the number of checks I can write?

No, there is no limit.

Can I make deposits into the account?

No, deposits cannot be made into the Sun Life Financial Benefit Account.

How can I keep track of my account?

Each month you will receive a statement listing all checks written, the interest credited to your account, any interest rate changes, and any special services that have been requested.

Is my account subject to unclaimed property laws?

Yes. Your account has been established as the result of payment of your life insurance proceeds and, therefore, continues to be subject to the applicable laws for unclaimed property.

Sun Life Financial monitors the activity on all accounts. If there has been no activity on an account for two years, we will attempt to contact the account owner of record at that time. It is important that you respond to this letter should you receive one.

Is my account insured by the Federal Deposit Insurance Corporation (FDIC)?

No. Your account is not insured by the FDIC. Your account is an obligation of the Sun Life Financial insurance company that issued the life insurance policy and is backed by it. The Sun Life Financial insurance companies enjoy strong financial strength ratings. Independent rating agencies place them among the highest-rated insurance companies in the United States.

How can I reorder checks?

An order form for an additional supply of checks will be included in your welcome package.

Can I designate a beneficiary for the proceeds of this account?

Yes. The package will include a form to designate a beneficiary to whom the proceeds remaining in the account will be payable in the event of your death. If no beneficiary is named, the proceeds will be payable to your estate.

What if my address changes?

Any change of address needs to be communicated in writing. You can use the change of address form included in the package or send a written notice to our Customer Service Department.

Sun Life Financial Benefit Account: FAQs *continued*

Can I stop payment on a check?

Yes. You may order a stop payment by calling our Customer Service Center at 866-223-9149. There is a $15 charge for each stop payment.

Can I request copies of cancelled checks?

If you need a copy of a check, call our Customer Service Center at 866-223-9149. We will send copies of checks to you as soon as possible. There is a $5 charge for each copy.

How is the interest earned on my account reported to the IRS?

At the end of each year, we generate an IRS Form 1099 indicating the annual interest credited to the account. We then send the form to you and to the IRS. You may wish to consult a tax, investment, or other financial adviser regarding tax liability and investment options.

How can I close my account?

You can close your account in one of three ways:

- Simply write a check in the amount of the balance indicated on your most recent statement and bring it to your local bank. Because interest is accrued daily, it may be difficult to know the exact balance. We will send a check containing any remaining interest within 30 days.
- Send a written request to Sun Life Financial Benefit Account, Insurance Services, P.O. Box 535412, Pittsburgh, PA 15253-5412, indicating that you wish to close the account. Please be sure to include your account number. We will mail a check for the full account balance including interest posted to that day.
- Let the balance of the account fall below $250. At the end of each month, accounts with $250 or less are automatically closed. We will send the balance in the account plus accrued interest to you.

Note: The National Association of Insurance Commissioners (NAIC) advises that you can contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com – 703-481-5206) to learn more about coverage and limitations for retained asset accounts by State Guaranty Associations. For further Information, you may also contact your State Department of Insurance. Louisiana residents may write to Louisiana Department of Insurance, 1702 N. Third Street, P.O. Box 94214, Baton Rouge, LA 70802 or call 1-800-259-5300.

5 Certifications and Signature

The IRS does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Cross out item 2 if the IRS has notified you that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Under penalties of perjury, I certify that

1. the Tax Identification Number shown above is correct; and
2. I am not subject to backup withholding because
   a. the IRS has not notified me that I am subject to backup withholding as a result of my failure to report all interest or dividends; or
   b. the IRS has notified me that I am no longer subject to backup withholding.

I certify that the above statements are true and complete.

Signature X	Date (m/d/y)

6 Additional Instructions

If the Beneficiary is the Estate

In some cases, life insurance may be payable to the insured's estate. The employer's Group Policy specifies the situations under which benefits are payable to the estate.

Payment of the life insurance benefits in these cases will be made to the executor or administrator of the estate. The executor or administrator is appointed by a probate court and is responsible for managing the insured's estate. Please note that a person named as the executor or administrator in the insured's last will & testament must be appointed by the court before payment can be made. The executor or administrator of the estate should complete the Claimant's Statement and provide a certified copy of the Letters Testamentary or Letters of Administration issued by the probate court. The estate tax identification number (not the Social Security number) is required on the Claimant's Statement.

If the Beneficiary is a Minor

If the beneficiary is a minor and does not have a guardian of his or her estate, we can pay a life insurance benefit to an adult member of the minor's family up to the limit of your state's Uniform Transfers to Minors Act (UTMA).

For benefits greater than the state UTMA limit, we will pay the benefit to a court appointed guardian of the minor's estate. The guardian must provide us with a certified copy of the court document appointing the guardian and must complete and sign the Claimant's Statement as guardian. The guardian should enter the minor's Social Security number and date of birth on the Claimant's Statement.

If no guardian of the minor's estate is appointed, we will pay the benefit into a Sun Life Financial Benefit Account. The Sun Life Financial Benefit Account is immediately available to the guardian of the estate once the guardian has been appointed and to the minor once he or she reaches the age of majority.

If the Beneficiary is a Trust

After Sun Life Assurance Company of Canada receives notice that the beneficiary of a policy is a Trust, we will prepare and send a Verification of Trust form to be completed by the Trustee and returned for file. We will also accept a certified copy of the Trust documents. The trustee should complete the Claimant's Statement. The trust's Tax Identification Number, (not the Social Security number), is required on the Claimant's Statement. Please provide copies of trust document.

If the Insured Died Accidentally

When the insured's death is the result of an accident, accidental death benefits may be payable if:

- **The Group Policy and employee class contain accidental death benefits**
- **The cause of death is "accidental" as defined under the Group Policy**
- **The Policy exclusions do not apply (please refer to the Group Policy)**

The official police or emergency technician report of the accident must be furnished to determine if accidental benefits are payable. If a toxicology test is administered, the official results of the test must be provided. If no toxicology test was administered, we will need a letter from the Medical Examiner or admitting hospital or coroner confirming that. We may need other information or reports to determine if the death is accidental under the terms of the Policy.

Section C: Authorization

Authorization for release and disclosure of health-related information

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:

Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care 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, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record 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 re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 Life Claims Department, Sun Life Assurance Company of Canada, SC 4375, 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

Authorization for release and disclosure of psychotherapy notes

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:

Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care 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 re-insurers.

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, health care professional, hospital, clinic, medical facility, or other health care 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 re-disclosed 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 Life Claims, Sun Life Financial, P.O. Box 81365, 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

Authorization for release and disclosure of non-health-related information

This authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign, and submit all authorizations in this packet. Failure to submit all authorizations could result in a delay during the claims process.

Return to:

Sun Life Financial
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481
Fax: 888-551-2084

I HEREBY AUTHORIZE any (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf; (b) benefits plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; or (i) government agency, or (j) the Medical Information Bureau, Inc. or Pharmacy Information Bureau, 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 re-disclosed 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 Group Life Claims, Sun Life Financial, P.O. Box 81365, 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