Sun Life Assurance Company of Canada

Long Term Disability Claim Packet – Attending Physician

Instructions for the Attending Physician

Please be sure to submit the Attending Physician's Statement directly to Sun Life Financial.

The Attending Physician must:

☐ Complete, sign and date the Attending Physician's Statement

☐ Submit the Attending Physician's Statement directly to Sun Life Financial

Mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

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

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet – Attending Physician

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 – AR, KY, LA , MA , MN, NM, 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 - 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 - 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: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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 – MD: 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 - 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 Warnings continued

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 – PA: Any person who knowingly and with intent to defraud any insurance company or any other person files a claim for insurance, 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 – 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

Long Term Disability Claim Packet – Attending Physician

Sun Life Financial®

Attending Physician's Statement – Physical conditions only

1 Patient Information

Please print clearly

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

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Do you believe this patient is competent to endorse checks? ..... ☐ Yes ☐ No		

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications		
Objective findings/investigative testing (i.e., x-rays, EKGs, MRIs, laboratory data, etc.)		
Subjective findings		
Date symptoms first appeared or date of accident	If injury due to a motor vehicle accident, indicate in which state the accident occurred.	
Patient's Height:	Patient's Weight:	Blood Pressure:
Is condition due to injury/sickness arising out of patient's employment? ... ☐ Yes ☐ No ☐ Unknown		
Names and addresses of other treating physicians (if applicable)		
If pregnancy, please provide the following information: • Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No		
Describe any complications that would extend this disability longer than a normal pregnancy		

3 Treatment

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

Date of first visit	Date of last visit	Date of last examination
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		

Continued on next page

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

In a typical work day, patient is able to:

	Continuously	Frequently	Occasionally	Negligible
Drive	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Lift _____ lbs.	☐	☐	☐	☐
Carry _____ lbs.	☐	☐	☐	☐

Is the patient capable of working within these restrictions/limitations? ..... ☐ Yes ☐ No

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

Continued on next page

6 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ longer

7 Remarks

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 on page 2 of this packet.

Name of Attending Physician (first, middle initial, last)		Degree/Specialty	
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Please be sure to return the completed Attending Physician's Statement to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet – Attending Physician

Attending Physician's Statement – Behavioral health conditions only

1 Patient Information

Please print clearly

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

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)

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

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. Thank you.

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:

2 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

Continued on next page

2 Treatment Information continued

Has there been any psychological testing? If available, provide results. If not, why? Are there any plans in the future to perform testing?
Current treatment methods/treatment plan, please describe.
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.

3 Prognosis

How long will those limitations apply? (estimated)

☐ 6 weeks ☐ 8 weeks ☐ 12 weeks ☐ longer

4 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 on page 2 of this packet.

Name of Attending Physician (first, middle initial, last)		Degree/Specialty	
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Please be sure to return the completed Attending Physician's Statement to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant

Instructions for the Claimant

Please mail all documents 4-6 weeks before the end of your elimination period.

Please make sure to initiate the Long Term Disability claim filing process as soon as it first appears that your disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

Please be sure to submit the Employee's Statement directly to Sun Life Financial.

The Employee must:

- ☐ Sign and date the Employee's Statement
- ☐ Sign and date the Authorizations
- ☐ Sign and date the Reimbursement Agreement
- ☐ Have the employer complete and return the Employer's Statement to Sun Life Financial
- ☐ Have the physician complete and return the Attending Physician's Statement to Sun Life Financial
- ☐ Attach a copy of a photo ID (i.e., license or passport)
- ☐ Attach a detailed job description (from employer)

Mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

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.

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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 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—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.

Continued on next page

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant

Employee's Statement

1 General Information

Please print clearly.

Return to:
Sun Life Assurance Company of Canada
Group LTD Claims,
SC 4328
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Name of employee (first, middle initial, last) ☐ M ☐ F	Social Security number	Group policy number
Street address	City	State / Zip Code
Occupation	Date of birth	Phone number / Marital status
Spouse's name (first, middle initial, last)	Social Security number	Date of birth

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 has occurred and is the cause of the disability, a motor vehicle accident report is required to be included with this statement.

Date of accident or date you first noticed symptoms of your illness _____

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	Last date worked prior to disability	Did you work a full day? ☐ Yes ☐ No
Date first unable to work	Have you returned to work? ☐ Yes ☐ No If yes, Date: ☐ With restrictions ☐ Full capacity	

If work-related, have you filed/do you intend to file, a Workers' Compensation claim? ☐ Yes ☐ No
If yes, provide date:

3 Your Treating Physician(s)

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

Name of physician	Specialty
Address	
Telephone number / Fax number / Date of last visit / Date of next visit	

Have you discussed a return to work plan with this physician?..... ☐ Yes ☐ No

Continued on next page

3 Your Treating Physician(s) continued

Name of physician			Specialty
Address			
Telephone number	Fax number	Date of last visit	Date of next visit
Have you discussed a return to work plan with this physician?..... ☐ Yes ☐ No			

4 Hospitals

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

1.	Name of hospital	Telephone number	Dates of confinement to
2.	Name of hospital	Telephone number	Dates of confinement to

5 Other Income Information

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

Check all that apply and provide award/denial notice or application associated with any 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 Education and Training Information

Please indicate your highest level of education completed. ☐ Less than High School (Grade: _____) ☐ High School (GED) ☐ College		
Name of school / college		
Degree	Dates attended	Field of study

Additional Course Work, Education, Training, Special Skills and/or Hobbies

7 Experience Information

Military Experience

Did you serve in the armed forces? ..... ☐ Yes ☐ No		Branch of service
Highest rank	Dates of service to	Specialty

Continued on next page

7 Experience Information continued

If you have a resume, please attach a copy. You may use this section to indicate any additional experience.

Work Experience

Please list chronologically all of the jobs you have held. Start with your current or most recent job. Provide as many details as possible.

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Name of Employer	Title	Dates of employment to
Department	Tasks and duties (please be specific)	

Skills Development

What, if any, training or education would you be interested in pursuing?

8 Checklist of Required Attachments

Please mail all documents 4-6 weeks before the end of your elimination period. **Failure to provide the following information could result in a delay of the initial benefit payment.**

- ☐ Sign and date the Employee's Statement
- ☐ Sign and date the Authorizations
- ☐ Sign and date the Reimbursement Agreement
- ☐ Employer completed and returned the Employer's Statement
- ☐ Physician completed and returned the Attending Physician's Statement
- ☐ Attach a copy of a photo ID (i.e., license or passport)

We will contact you as soon as we have received and reviewed your claim forms and medical records. In the meantime, should you have any questions, please call our Customer Service Center at 1-800-247-6875.

9 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 on pages 2 and 3 of this packet.

Employee's signature X	Date signed

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Sun Life Assurance Company of Canada

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 Assurance Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481

Fax: (781) 304-5537

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, SC 4328, 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

Sun Life Assurance Company of Canada

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 Assurance Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481

Fax: (781) 304-5537

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) 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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, SC 4328, 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

Sun Life Assurance Company of Canada

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 Assurance Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481

Fax: (781) 304-5537

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, SC 4328, 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

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Claimant

Reimbursement Agreement

Return to:
Sun Life Assurance
Company of Canada
Group LTD Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

I UNDERSTAND and agree that the provisions of Group Long Term Disability Policy No. _____ permit Sun Life Assurance Company of Canada (herein called the "Company") to offset from my monthly disability benefit any benefits received from Social Security and/or Workers' Compensation or as otherwise provided in the Group Long Term Disability Policy. I further UNDERSTAND and agree that the Company may offset any such amounts that I or my dependents are eligible to receive, whether or not I or my dependents are actually receiving said amounts.

In return for the Company's advance payment of the Long Term Disability benefits to which I may be entitled, which advanced amount may be in excess of the amount due to me under the terms of the policy, I, for myself, my heirs, executors, administrators and assigns agree:

1. That I am not currently receiving any benefits from Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy.
2. To apply for Social Security disability benefits and/or Workers' Compensation benefits, and/or any Other Income benefit to which I or my dependents may be eligible as described in the policy.
3. If I, and/or my spouse and family receive any disability payments, regardless of the amount, in connection with Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I or my spouse and family may be eligible as described in the policy; I and/or my spouse and family will immediately notify the Company of such disability payments and will pay back all amounts over and above the amounts to which I would be entitled under the policy provisions.
4. I understand that thereafter the Company is entitled to offset any amounts received from Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy with the monthly benefit payable under the policy in accordance with the terms of the policy.

I UNDERSTAND that the Company, in reliance on the above statements and promises, has agreed to advance to me the disability benefits to which I or my dependents are entitled under the terms of the policy.

Print name	Group policy number
Signature of employee X	Date
Signature of witness X	Date

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 upon 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

To take any of these actions, please contact us at the following address for further instructions:

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

Sun Life Assurance Company of Canada

Long Term Disability Claim Packet - Employer

Instructions for the Plan Administrator

Please call our Customer Service Center at 1-800-247-6875 from 8 a.m. to 8 p.m. Eastern Time to report any scheduled or actual return-to-work dates as soon as possible.

Please make sure that the employee initiates the Long Term 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.

Please be sure to submit the Employer's Statement directly to Sun Life Financial.

The Employer must:

- ☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.
- ☐ Attach copies of employee's medical information relating to the disability (if available).
- ☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.
- ☐ Attach a copy of all payroll documentation and attendance records for the last six months.
- ☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

NOTE:

FOR TRANSITION CLAIMS: If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes on page 4. Then complete the rest of the Employer portion of this claim packet.

FOR NON-TRANSITION CLAIMS: Fill out the entire Employer portion of this packet.

Mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Long Term Disability Claims
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

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 Warnings continued

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 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—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
Long Term Disability Claim Packet - Employer

Sun Life Financial®

Employer's Statement

1 General Information

Please print clearly.

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Return to:
Sun Life Assurance Company of Canada
Group LTD Claims,
SC 4328
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Name of employer		Group policy number	Class
Street address	City	State	Zip
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	Telephone number

2 Employee Information

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

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

3 Employment and Claim Information

If claimant is transitioning from a Sun Life Assurance Company of Canada Short Term Disability claim to a Long Term Disability claim, only fill in the shaded boxes.

Date hired (m/d/y)	Effective date of coverage	Date last worked (m/d/y)	Hours worked last day
What was the employee's permanent occupation on his/her last date of work?			
How long had employee been in 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 termination date	
Why did 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:		Telephone number	
Was employee covered under prior LTD policy? ..... ☐ Yes ☐ No	Effective date under prior policy (m/d/y)	Termination date under prior policy (m/d/y)	
Has employee returned to work? ☐ Yes ☐ No If yes: ☐ With restrictions ☐ Full capacity		Date returned (m/d/y)	

4 Salary and Benefits Information – Complete this section for **all** claimants.

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

Please provide 6 months of payroll records prior to date last worked. Be sure to include documentation of hours worked, payments, contributions to LTD, and attendance records.

How was the employee paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per week:

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

Enrollment form is required if coverage is contributory.

Does employee contribute toward the LTD 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.

Check all that apply and provide details for each source of income.

Is employee 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 Employee's Occupation Information – Complete this section for **all** claimants.

Required: Please submit a copy of the employee's formal job description.

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

7 Physical Aspects of Occupation – Complete this section for **all** claimants.

Please note that additional occupational information may be required.

In a typical work day, give the number of hours the employee spends in each of these positions and if employee may alternate positions.

Position	Total Number of Hours	May Alternate Positions: At Will	15-30 Mins.	Hourly	Never
Sitting		☐	☐	☐	☐
Standing		☐	☐	☐	☐
Walking		☐	☐	☐	☐
Driving		☐	☐	☐	☐

Continued on next page

7 Physical Aspects of Occupation continued – Complete this section for **all** claimants.

In a typical work day, the employee must:

	Occasionally (1/4 – 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)	Never
Bend/Stoop	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Crawl/Crouch	☐	☐	☐	☐
Lift _____ lbs.	☐	☐	☐	☐
Carry _____ lbs.	☐	☐	☐	☐

Does the employee use feet for repetitive movements, as in operating foot controls?
Right foot ☐ Yes ☐ No Left foot ☐ Yes ☐ No Both feet ☐ Yes ☐ No

What are the major tasks requiring use of one or both hands?

Check all that apply.

Which of the following describes the employee's working environment?

☐ Working at heights
☐ Operating heavy machinery
☐ Precise manual dexterity
☐ Exposure to dust, fumes and gases
☐ Changes in temperature or humidity
☐ Other hazards (specify): _____

8 Non-Physical Aspects of Occupation – Complete this section for **all** claimants.

Does employee have to answer customer complaints? ☐ Yes ☐ No
Is employee primarily evaluated on production? ☐ Yes ☐ No
Is employee routinely subject to close supervision? ☐ Yes ☐ No
Does employee work closely with his/her co-workers? ☐ Yes ☐ No
Is employee responsible for the overall performance of his/her particular department? ☐ Yes ☐ No
Number of people this employee supervises _____

9 Checklist of Required Attachments – Complete this section for **all** claimants.

Failure to provide the following information could result in a delay of the initial benefit payment.

☐ Attach a copy of the LTD enrollment form if the employee contributes to the premium.
☐ Attach copies of employee's medical information relating to the disability (if available).
☐ Attach a copy of the employee's formal job description or a detailed description of primary duties.
☐ Attach a copy of all payroll documentation and attendance records for the last six months.
☐ If Waiver of Premium claim, attach the Basic and/or Optional enrollment form, payroll record and other required documentation.

10 Certification and Signature – Complete this section for **all** claimants.

Tip: 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 on page 2 of this packet.

Name of person completing this form	Telephone number: Fax Number:
Title	E-mail address: Company's Website:
Signature X	Date signed

For more information about Long Term Disability, the claim process and the status of your employees' claims, log onto your plan administrator web portal.