Sun Life Assurance Company of Canada

Long-Term Disability Claim Statement – Attending Physician

Instructions

The Attending Physician must please complete each section of this form, and then sign and date it and return it to us.

You can submit this form and any additional documents by e-mail. mail or fax:

E-mail: myclaimdocuments@sunlife.com

Mail: Sun Life Assurance Company of Canada, 96 Worcester Street, Wellesley, MA 02481

Fax: 781-304-5537

If complete and accurate information is not provided, we may need to request additional information, which could delay disability benefits for your patient.

Group policy number

1 Patient information

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

Name of patient (first, middle initial, last)			☐ M ☐ F
Street Address	City	State	Zip code
Social Security number	Date of birth (mm/dd/yyyy)	Phone number	
Name of employer (Parent company name)			

2 Diagnosis and history

Please answer as completely as possible. This is important so we can process your patient's disability benefits quickly. If we need to follow up with you, your patient's benefits may be delayed.

Primary Diagnosis (include any complications)	ICD-10 Code
Secondary Diagnosis (if applicable)	ICD-10 Code
Has patient ever had the same or similar condition?..... ☐ Yes ☐ No If "Yes," provide date when condition previously occurred	

For a pregnancy, provide the following:

Expected due date (mm/dd/yyyy)	Actual delivery date (mm/dd/yyyy)	Delivery type ☐ Normal ☐ C-Section
List any complications that caused patient to stop working prior to the expected delivery or that would extend the normal recovery		

2 **Diagnosis and history**, continued

Is patient's injury/sickness work related? ..... ☐ Yes ☐ No ☐ Unknown

Diagnostic Testing Performed

Test	Date	Findings
☐ X-ray		
☐ EKG		
☐ MRI		
☐ PFT		
☐ U/S		
☐ Other:		

3 **Treatment detail**

Start date of disability	Date of first office visit	Date of last office visit	Date of next office visit

Was Emergency Room care required for the condition ..... ☐ Yes ☐ No		
Name of hospital	Date (mm/dd/yyyy)	Phone Number

Check all that apply and describe the type, frequency, and treatment (date and type)

☐ Surgery			
☐ Medications prescribed			
☐ Therapy			
☐ Behavioral intervention			
☐ Other			
Has patient	☐ Hospital Confined	Date from (mm/dd/yyyy)	Date to (mm/dd/yyyy)
	☐ House Confined	☐ Bed Confined	☐ Ambulatory
Hospital Name			

4 **Restrictions and limitations**

Describe what the patient is **unable to do.**	From To
Describe what the patient **should not do.**	From To

4 **Restrictions and limitations**, continued

Is patient capable of working with these restrictions/limitations?..... ☐ Yes ☐ No
☐ Full-time ☐ Part-time: hours/day
If capable of part-time, how long will patient be limited to a part-time schedule?
Do you believe this patient is competent to endorse checks and manage financial affairs? ..... ☐ Yes ☐ No

Sun Life believes that Work is Healthy. We seek to maximize your patient's recovery. Our vocational staff is available to partner with you in focusing on your patient's abilities and returning them to wellness and work.

Patient's dominant hand is: ☐ Left ☐ Right

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

	Simple Grasping	Firm Grasping	Fine Manipulation	Key Boarding
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

In a typical workday, the patient is able to: **(This is not considered an FCE)**

	Continuously	Frequently	Occasionally	Negligible
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐
Lift (lbs.)	☐	☐	☐	☐
Carry (lbs.)	☐	☐	☐	☐
Drive	☐	☐	☐	☐
Left foot pedal	☐	☐	☐	☐
Right foot pedal	☐	☐	☐	☐

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

☐ No limitation ☐ Marked limitation ☐ Slight limitation ☐ Complete Limitation
How long will these limitations apply? (estimated) ☐ 6-8 weeks ☐ 8-12 weeks ☐ 12-26 weeks Expected recovery date (mm/dd/yyyy):

Mental Impairment (if applicable)	**Current DSM diagnosis**
☐ Class 1 – No limitation	
☐ Class 2 – Slight limitation	
☐ Class 3 – Moderate limitation	
☐ Class 4 – Marked limitation	
☐ Class 5 – Severe limitation	

5 Return-to-work information

Indicate the specific date or recovery period after which the patient will be able to sufficiently perform duties.

Patient can return to his/her part-time occupation in: Date (mm/dd/yyyy): _____ **-or-**

☐ 1-2 weeks ☐ 2-3 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 6-7 weeks ☐ 7-8 weeks

☐ 2 months or more ☐ Never ☐ Other:

Patient can return to his/her full-time occupation in: Date (mm/dd/yyyy): _____ **-or-**

☐ 1-2 weeks ☐ 2-3 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ 6-7 weeks ☐ 7-8 weeks

☐ 2 months or more ☐ Never ☐ Other:

6 Other treating physicians

Name of physician		
Specialty	Phone number	Fax number

Name of physician		
Specialty	Phone number	Fax number

If you need more room, check ☐ here and attach a separate sheet.

7 Certification and signature

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

Name of Attending Physician (first, middle initial, last)			Tax ID #
Street address	City	State	Zip code
Specialty	Phone Number		Fax Number

Attending Physician signature X	Date signed (mm/dd/yyyy)

6 Fraud warnings

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

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

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

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

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

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

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

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

DE, ID and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

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

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

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

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

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

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

NM: 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 civil fines and criminal penalties.

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.

6 **Fraud warnings**, continued

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

OR: Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

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

RI: 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.

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

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

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.

Contact us

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www.sunlife.com/us

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

Sun Life Assurance Company of Canada

Long-Term Disability Claim Statement - Employee

Instructions

Please submit a disability claim if you have a disability that extends beyond the elimination period that's included in your employer's group policy.

Please complete, sign and date this form, including the medical authorizations, and return it to us along with the following documents (as applicable):

- Reimbursement Agreement
- Direct Deposit Authorization
- Third Party Authorization

You may also submit this statement online at www.sunlife.com/us, click on Submit a Disability Claim. Please send the additional documents by e-mail, mail or fax:

E-mail: myclaimdocuments@sunlife.com

Mail: Sun Life Assurance Company of Canada, 96 Worcester Street, Wellesley, MA 02481

Fax: 781-304-5537

If complete and accurate information is not provided, we may need to request additional information, which could delay your disability benefits.

Name of employer (parent company name)	**Group policy number**

1 General information

Name of employee (first, middle initial, last) ☐ M ☐ F		Social Security number	Date of birth (mm/dd/yyyy)	
E-mail address*				
Street Address	City		State	Zip code
Occupation	Home phone number	Cell phone number	Marital status	
Spouse's name (first, middle initial, last)		Social Security number	Date of birth (mm/dd/yyyy)	

Can we leave you a detailed voicemail if we are unable to reach you by phone? ☐ Yes ☐ No

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

Sun Life believes that work is healthy. We hope that we can be of assistance in getting you safely back to work.

Last day worked (before disability)	Date first treated by Physician	Date expected to return to work

Did you require Emergency Room care for your condition? ☐ Yes ☐ No		
If "Yes," provide hospital name	Date (mm/dd/yyyy)	Hospital phone number

Were you confined to a hospital for this condition? ☐ Yes ☐ No		
If "Yes," provide hospital name	Date(s) of confinement (mm/dd/yyyy) From: To:	Hospital phone number

Select the appropriate type of condition, and provide details:

☐ Motor vehicle accident
☐ Attached accident report with this statement

☐ Pregnancy

Expected due date (mm/dd/yyyy)	Actual delivery date (mm/dd/yyyy)	Delivery type ☐ Normal ☐ C-Section
Complications		

☐ Injury

Date of injury (mm/dd/yyyy):	Where occurred:
Cause of injury/sickness:	

☐ Sickness

Date of first symptom (mm/dd/yyyy)	Type of sickness
Have you experienced symptoms in the past? ☐ Yes ☐ No If "Yes," provide the date	

Do you intend to file for Workers' Compensation? ☐ Yes ☐ No If "Yes," what is the status? ☐ Denied ☐ Approved ☐ Pending ☐ Appealed

3 Other income information

If you receive other income, please provide us with any approval/denial letters.

	Source of Income	Weekly or monthly	Payment Amount
☐	Sick Pay	☐ Weekly ☐ Monthly	$
☐	Salary Continuance	☐ Weekly ☐ Monthly	$
☐	State Disability	☐ Weekly ☐ Monthly	$
☐	Workers' Compensation	☐ Weekly ☐ Monthly	$
☐	Unemployment	☐ Weekly ☐ Monthly	$
☐	Social Security Disability	☐ Weekly ☐ Monthly	$
☐	Disability/Retirement Pension	☐ Weekly ☐ Monthly	$
☐	Other:	☐ Weekly ☐ Monthly	$

4 Education, Training, and Experience

Please indicate the highest level of education you have completed

☐ Less than High School Grade (Grade:)	☐ High School (GED)	☐ College
Name of school / college		
Degree	Dates attended	Field of study

Sun Life believes that work is healthy and we hope that we can help you get safely back to work. Please contact us if you have any questions about our return to work services and incentives.

1. Since you became disabled, have you acquired, or do you plan to acquire any additional education or training? ..... ☐ Yes ☐ No
2. Are you working or have you worked at any time since you became disabled? ..... ☐ Yes ☐ No

   If "Yes," has it been for any employer or in self-employment?

If "Yes," please describe.

Military Experience

Did you serve in the armed forces? ..... ☐ Yes ☐ No

Branch	Highest rank
Dates of service (mm/dd/yyyy) From: To:	Specialty

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

Prior Work Experience

Name of employer	Title	Dates of employment (mm/dd/yyyy) From: To:
Tasks and duties (please be specific)		
Name of employer	Title	Dates of employment (mm/dd/yyyy) From: To:
Tasks and duties (please be specific)		

Are you: ☐ Left-handed ☐ Right-handed	Computer keyboard familiarity: ☐ None ☐ Basic ☐ Proficient

Do you have a computer? ..... ☐ Yes ☐ No
Do you use: ☐ Word Processing software ☐ E-mail ☐ Internet ☐ Excel ☐ Powerpoint ☐ Other:

5 Physician information

List physicians you are seeing or have seen for this condition.

Name of physician			Specialty
Address			
Phone number	Fax number	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)
Have you discussed a return to work plan with this physician? ☐ Yes ☐ No			

Name of physician			Specialty
Address			
Phone number	Fax number	Date of last visit (mm/dd/yyyy)	Date of next visit (mm/dd/yyyy)
Have you discussed a return to work plan with this physician? ☐ Yes ☐ No			

If you need more room, check ☐ here and attach a separate sheet.

6 Signature

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

Employee's signature X	Date signed (mm/dd/yyyy)

*By providing your e-mail address, you consent to electronic delivery of information and communications, including legally required notices or disclosures, about your claim and all future claims with Sun Life. In order to receive electronic communications from us, you must have access to a computer or mobile device with an Internet connection, a valid e-mail account and software to access it.

You will be required to create a password and log in to the Sun Life Certified Mail portal in order to access the communications. A communication posted to the portal will be considered to have been delivered to you when Sun Life sends an e-mail message to your e-mail address on file with Sun Life informing you that the communication is available for review on the portal.

You may withdraw your consent, update your e-mail address, or request a paper copy of any electronic document by contacting Sun Life at 1-800-247-6875.

Even if you have provided your e-mail address and consented to electronic delivery, Sun Life may at its option deliver communications to you on paper and require that certain communications and other information from you be delivered to Sun Life on paper. If you provide us with an invalid e-mail address, or if there is a subsequent malfunction of a previously valid e-mail address, Sun Life may treat this as a withdrawal and termination of your consent to receive electronic communications.

7 Fraud warnings

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

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

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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.

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7 **Fraud warnings**, continued

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

OR: Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

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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.

Contact us

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By fax
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By e-mail
myclaimdocuments@sunlife.com

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

Sun Life Assurance Company of Canada

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.

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services tome or on my behalf to, or has medical or health related records or knowledge of me, 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, employees, agents, representatives, 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 may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates, (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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 of signature; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 96 Worcester Street, 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 claimant or personal representative of claimant	Group policy number
If representative, description of your authority or relationship to claimant	Claimant date of birth (mm/dd/yyyy)
Signature of claimant or personal representative X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Authorization for Release and Disclosure of Psychotherapy notes

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, , medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf, or has medical or health related records of knowledge of me, to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, employees, agents, representatives, 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, 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 may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates, (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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 Sun Life Assurance Company of Canada, 96 Worcester Street, 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	Claimant date of birth (mm/dd/yyyy)
Signature of employee or personal representative X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Authorization for Release and Disclosure of Non-Health Related Information

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, or has medical or health related records of knowledge of me; (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, employees, agents, representatives, 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 may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates; (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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 no longer than 24 months from the date of signature below; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 96 Worcester Street, 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 claimant or personal representative of claimant	Group policy number
If Representative, description of your authority or relationship to claimant	Claimant date of birth (mm/dd/yyyy)
Signature of claimant or personal representative X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Privacy Information Notice – Group Insurance

Sun Life Assurance Company of Canada ("the Company"), a member of the Sun Life group of companies, provides insurance and other financial services to our customers. As part of these services, we are trusted with confidential information. We take this responsibility seriously. All of our employees and our authorized representatives recognize the importance of maintaining confidentiality. The Company gathers information about you to determine fair and reasonable rates for your insurance. Once you are a policyholder, we will need information about you to:

- provide a number of services,
- reinstate a policy; or
- evaluate requests for changes in coverage.

Confidentiality

Insurance companies are among the largest gatherers of information about people. The Company has long been aware of the importance of guarding the confidentiality of such information. We have internal standards and controls governing its use. All employees must follow the procedures outlined in our Code of Business Conduct. Other than as required or allowed by law, the information gathered will not be released to anyone without your authorization or consent.

Collection of Information

We need to obtain information about you to determine whether we can provide the insurance coverage you have requested and to determine a fair and reasonable premium for it. We also use the information we obtain from you to maintain and service your account.

The information collection process begins when you apply for insurance. The application for insurance seeks basic information about you, e.g., your name and address, as well as more detailed information about your health. As part of the application 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.

The Company may also request that you submit to certain laboratory tests. Such tests may include an analysis of blood, urine and/or saliva. The testing is done by a licensed laboratory and the results are sent directly to us.

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

- physicians, health care providers, health plans, medical professionals, hospitals, clinics, laboratories, therapists, pharmacy benefit managers, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or health care related facilities;
- benefit plan administrators;
- employers;
- other insurance companies you have applied to for insurance;
- insurance support organizations;
- financial institutions;
- government agencies, such as the Social Security Administration, the Internal Revenue Service, or the Veteran's Administration;
- public records, such as motor vehicle records; and
- consumer reporting agencies.

Information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

The Underwriting Process

Group medical underwriting is a process by which an insurance company assesses the health of individual applicants to determine if they qualify for insurance coverage above the guarantee issue limit. The information obtained as part of this process may consist of:

- a medical examination;
- blood and urine tests;
- special tests;
- medical records from health care providers or hospitals;
- motor vehicle reports; and/or
- other information collected from the sources described in the above section.

Using this information, the underwriters will further evaluate the risk based on other factors, such as:

- tobacco use;
- driving record; or
- hazardous activities.

After the evaluation process is completed, the underwriter may not accept the risk. If we do not accept the risk, you will be notified. You have the right to request in writing the reason for this action within ninety (90) business days of the date we mail you the notice or other communication of the adverse underwriting decision. You must complete a written authorization and send it to our medical underwriting manager. We will promptly send the requested information. In those states that prohibit the release of sensitive information directly to the prospective Insured, we will do so through a named physician or health department.

Please send this type of request to:

Sun Life Assurance Company of Canada
Group Medical Underwriting
Attention: Medical Underwriting Manager
P.O. Box 81344
Wellesley Hills, MA 02481

Laboratory Testing

To assist in determining your eligibility for insurance, the Company may request some lab testing to be completed. This could include an analysis of blood, urine and/or saliva obtained as part of your insurance exam. The testing is done by a licensed laboratory and the results will be sent directly to us.

The blood testing may include tests for:

- HIV antibody;
- diabetes;
- kidney and liver functions;
- hepatitis;
- cholesterol;
- other tests.

Urine testing may include tests for:

- diabetes;
- kidney function;
- prescription medications;
- drugs of abuse; and
- nicotine/cotinine tests.

As with the rest of your medical information, all test results are treated confidentially and shared only with your authorization and consent, except as required by law. Some states require the reporting of positive tests for HIV and for hepatitis to the state department of health.

Disclosure of Personal Information

When you sign the Authorization for Release and Disclosure of Health Related Information, the Authorization for Release and Disclosure of Non-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:

- any other insurance company you have applied to for insurance;
- third party administrators;
- rehabilitation or vocational professionals;
- your treating physician, psychologist or therapist/counselor, for the purpose of verifying, evaluating, negotiating, determining and/or adjudicating your claim for insurance benefits;
- your employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which you participate or leave/accommodation services associated with your employment;
- other persons or organizations performing medical, investigative, financial or legal services related to your claim;
- the Company's subsidiaries and affiliates; or
- as required or permitted by law.

In the course of underwriting your application or maintaining or servicing your account, 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; and
- comply with federal, state or local laws; to respond to a subpoena; or to comply with an inquiry by a governmental agency or regulator.

Access, Correction, Amendment or Deletion of Personal Information

Upon written request to the Company, you can:

- request that we inform you of the nature and substance of the personal information we have about you;
- obtain a copy of the personal information we have about you in our files, and the identity of the medical professional or institutional source(s) of that information, either by mail or in person if you prefer (a fee may be charged to cover the cost of providing a copy of such information);
- request that we disclose to you the identity, if recorded, of those persons to whom we disclosed your personal information within the two (2) years prior to your request (or, if not recorded, the names of those persons to whom we normally disclose such information);
- request that we correct, amend, or delete any personal information about you in our possession; and
- file your own statement of facts if you believe that the personal information we have about you is incorrect.

To take any of these actions, please contact the Company for further instructions. We will respond to your written request within thirty (30) business days from receipt of your request. If we refuse your request to correct, amend, or delete your personal information, we will notify you of the reason(s) for our refusal. If you disagree with our decision, you will have the right to file a concise statement with us setting forth what you think is the correct, relevant or fair information and why you disagree with our refusal to correct, amend or delete your personal information.

Contact us

By mail
Sun Life Assurance Company of Canada
96 Worcester Steet
Wellesley Hills, MA 02481

www.sunlife.com/us

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

State Notices

As an addition to the Access, Correction, Amendment or Deletion of Personal Information section:

For residents of Arizona: Upon your request, we will reconsider our underwriting decision based on any corrected information or your own statement of facts.

For residents of California: Please go to www.sunlife.com/us and select the privacy link at the bottom of the page to read our California Privacy Policy and Notice and other related privacy notices.

For residents of Minnesota: If we refuse to correct, amend or delete disputed personal information, you may file an appeal with your Insurance Commissioner.

If a health care professional or a health care institution has provided us health information that the health professional or health care institution has determined and indicates in writing that the release of the health record information is detrimental to your physical or mental health or is likely to cause you to inflict self-harm or to harm another, we may provide the information directly to you only with the approval of the health professional with treatment responsibility for the condition to which the information relates. If approval is not obtained, the information must be provided to the health professional designated by you.

For residents of Montana: Your Insurance Commissioner may review a refusal by us to correct, amend or delete any recorded personal information in order to determine if the information is correct. Your Insurance Commissioner may order us to correct, amend or delete information that the Insurance Commissioner determines is erroneous in your recorded information file.

For residents of Virginia: Disclosure directly to you may be denied if a treating physician, clinical psychologist, or clinical social worker has determined, in the exercise of professional judgment, that the disclosure requested would be reasonably likely to endanger your life or physical safety or that of another or that the information requested makes reference to a person other than a health care provider and disclosure of such information would be reasonably likely to cause substantial harm to the referenced person.

If disclosure to you is denied, you may request we either:

(i) designate a physician, clinical psychologist, or clinical social worker acceptable to us who was not directly involved in the denial, and whose licensure, training, and experience relative to your condition are at least equivalent to that of the physician, clinical psychologist, or clinical social worker who made the original determination, who shall, at our expense, make a judgment as to whether to make the information available to you; or

(ii) if you so request, make the information available, at your expense to a physician, clinical psychologist, or clinical social worker selected by you, whose licensure, training, and experience relative to your condition are at least equivalent to that of the physician, clinical psychologist, or clinical social worker who made the original determination, who shall make a judgment as to whether to make the information available to you.

We shall comply with the judgment of the reviewing physician, clinical psychologist, or clinical social worker made in accordance with the foregoing procedures.

As an addition to the Access, Correction, Amendment or Deletion of Personal Information section:

For residents of New Mexico: Pursuant to the New Mexico Domestic Abuse Insurance Protection Act, and insurance regulations promulgated thereunder, we are required to inform you that the medical and other records provided to us as part of the routine underwriting review may include confidential abuse information. The term “confidential abuse information” includes, for example, information about acts of domestic abuse or abuse status, or the work or home address or telephone number of a victim of domestic abuse. We are prohibited by law from using confidential abuse status as the sole basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating insurance coverage, restricting or excluding coverage or benefits or charging a higher premium. The Domestic Abuse Insurance Protection Act provides you with certain rights to access confidential abuse information received by us and to have that information corrected if it is not accurate.

We are also required to inform you that those who are or have been victims of domestic abuse, or provide shelter, advocacy, counseling or protection to victims of domestic abuse, may request participation as a “protected person” under our location information confidentiality program. This means that we will take measures, as may be required by applicable New Mexico insurance regulations, to help maintain the confidentiality of certain location information in our records. The term “location information” means your address, home telephone number, place of employment, school or other location information. Please notify us, at the contact information provided in The Underwriting Process section, if you wish to participate in this program.

Sun Life Assurance Company of Canada

Reimbursement Agreement - Group Disability

I UNDERSTAND and agree that the provisions of Group 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 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 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	Date of birth (mm/dd/yyyy)
Signature of employee X	Date
Signature of witness X	Date

Contact us

By mail
Sun Life Assurance Company of Canada
96 Worcester Street
Wellesley Hills, MA 02481

By fax
Short-Term Disability Claims: 781-304-5599
Long-Term Disability Claims: 781-304-5537

By e-mail
myclaimdocuments@sunlife.com

www.sunlife.com/us

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

Sun Life Assurance Company of Canada

Direct Deposit Authorization

To enjoy the safety and convenience of Sun Life Assurance Company of Canada's direct deposit services, simply complete this form with your Checking account information and return it to your Sun Life Assurance Company of Canada representative. Please note we cannot receive Savings account information.

1 Insured information (please print clearly)

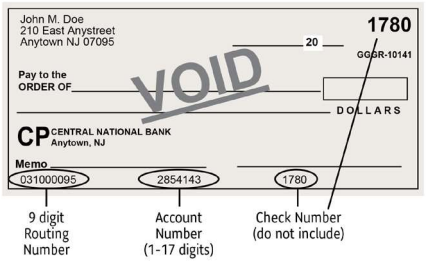
First name	Middle initial	Last name	Date of birth (mm/dd/yyyy)

Street address	City	State	Zip code

Employer name	Group policy number

Name of authorized representative signing this form (if applicable)	Title	Phone number

2 Financial institution



Name of individual(s) on Checking Account	
Name of bank or financial institution	City and state of bank or financial institution
Insured/employee's **Routing** number at bank or financial institution	Insured/employee's **Checking Account** number at bank or financial institution

3 Insured authorization statement

I hereby authorize Sun Life Assurance Company of Canada, including any of its subsidiaries and affiliates, ("Sun Life") to make all payments due under the policy listed above by direct deposit to the account designated above. This authorization shall be effective until further written notice from me, or another legally authorized representative, is received by Sun Life. I understand that Sun Life needs at least five (5) business days to process any change to this authorization.

I certify that the above listed account information accurately reflects the correct Checking account number and routing number. I agree not to hold Sun Life responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or due to an error on the part of my financial institution, in depositing funds to my account.

To correct any overpayments credited to this account, I hereby authorize and direct the financial institution designated above to debit this account and refund such overpayment to Sun Life.

Signature of insured/employee X	Date (mm/dd/yyyy)
Signature of authorized representative (if applicable) X	Date (mm/dd/yyyy)

Contact us

By mail
Sun Life Assurance Company of Canada
96 Worcester Street
Wellesley Hills, MA 02481

By fax
Short-Term Disability Claims: 781-304-5599
Long-Term Disability Claims: 781-304-5537

By e-mail
myclaimdocuments@sunlife.com

www.sunlife.com/us

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

Sun Life Assurance Company of Canada

Third Party Authorization - Group Disability Claims

You are not required to sign this optional authorization. However, to authorize Sun Life Assurance Company of Canada and its affiliates (collectively "Sun Life") to communicate with a family member, friend or other third party about your Disability claim, we need your consent.

To provide your consent, please complete, sign and date this authorization, then return it by mail, fax or e-mail using the information provided in the "Contact us" section below.

Claim control number ("my claim")	**Group policy number**

1 Authorized person(s)

To assist in the evaluation or administration of my claim, I authorize Sun Life to share information about my claim with the following "authorized person(s)":

Name	Relationship to employee

Phone number	E-mail

2 Signature(s)

If you are signing this form on behalf of the employee as a power of attorney, trustee, guardian, custodian, conservator, or designee, please sign in your fiduciary capacity. We will also need your authorizing documents to communicate with you. Please attach them to this form.

I/we acknowledge that I/we have read and agree to the following terms and conditions of this authorization.

- I/we authorize Sun Life to leave messages about my claim on my voice mailboxes and the voice mailboxes of the authorized person(s) listed above.
- I/we understand that information about my claim may include information about my health, my claimed disability, my work status, the terms of my coverage, and any potential benefits that may be available to me.
- I/we understand that this authorization is limited solely to sharing information related to my claim and that no third party is authorized to make decisions on my behalf with respect to my claim.
- I/we understand that this authorization is valid for the duration of my claim. If a new claim is started, a new Authorization form is needed for that claim. I further understand that I may withdraw this authorization at any time by notifying Sun Life in writing that this authorization is withdrawn.
- I/we understand that my authorized representative and I are entitled to receive a copy of this authorization upon request. I/we also understand that a copy of this authorization shall be valid as the original.

Employee name	Date of birth (mm/dd/yyy)
Signature X	Date signed (mm/dd/yyyy)

Authorized representative name (if applicable)	Relationship to employee
Signature X	Date signed (mm/dd/yyyy)

Contact us

By mail
Sun Life Assurance Company of Canada
96 Worcester Street
Wellesley Hills, MA 02481

By fax
Short-Term Disability Claims: 781-304-5599
Long-Term Disability Claims: 781-304-5537

By e-mail
myclaimdocuments@sunlife.com

www.sunlife.com/us

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

Sun Life Assurance Company of Canada

Long-Term Disability Claim Statement - Employer

Instructions

Please complete this Disability Claim Statement for an employee who has a disability that extends beyond the elimination period that's included in your group policy.

Please complete, sign and date this form, and return it to us along with the following documents (as applicable).

- Enrollment form
- Job description
- Attendance records
- Workers' Compensation report
- Return-to-Work slip
- W-2
- 3 months of detailed payroll

You may also file this form online at www.sunlife.com/us, click on Submit a Disability Claim. Please send the additional documents by e-mail, mail or fax:

E-mail: myclaimdocuments@sunlife.com

Mail: Sun Life Assurance Company of Canada, 96 Worcester Street, Wellesley, MA 02481

Fax: 781-304-5537

If complete and accurate information is not provided, we may need to request additional information, which could delay disability benefits for your employee.

Group policy number

1 General information

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

Does your company have a formal Return-to-Work Program..... ☐ Yes ☐ No

Contact person	Phone number

2 Employee's information

Name of employee (first, middle initial, last)		☐ Male ☐ Female	Class per contract	
Employee's street address		City	State	Zip code
Social Security number	Date of birth (mm/dd/yyyy)	Phone number	E-mail address	

3 Employment and claim information

Date hired:	Start date of disability insurance:	Date last worked before disability:	Hours worked last day:
Employee's job title			
List employee's major job duties (include a copy of the job description if available)			
How would you classify the employee's occupation? ☐ Sedentary (1-10lbs) ☐ Light (11-20lbs) ☐ Medium (21-50lbs) ☐ Heavy (51+ lbs)			
Indicate the days per week the employee regularly works. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7			
Indicate daily hours the employee regularly works ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Other:			
Has employee's employment terminated? ..... ☐ Yes ☐ No If "Yes," termination date:			
Has employee returned to work? ..... ☐ Yes ☐ No If "Yes," return date: ☐ Full-time (full capacity) ☐ Full-time (partial capacity) ☐ Part-time (attach payroll ledger)			
Is condition due to injury/sickness caused by employee's occupation? ..... ☐ Yes ☐ No ☐ Unknown			
Has a Workers' Compensation claim been filed? ..... ☐ Yes ☐ No			
Name of Workers' Compensation carrier		Phone number	

4 Salary and benefit information

If the employee contributes to the premium, attach a copy of employee's enrollment form.

How was the employee paid? (check one)

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

Other work-related income:

Commissions $	Bonuses $	Overtime $

How does the employee contribute toward the premium? ☐ PRE-tax ☐ POST-tax ☐ Employee does not contribute
If employee contributes, please provide percentage %

5 Other income information

Indicate whether the employee is currently receiving or entitled to receive benefits from any of these sources.
Check all that apply.

	Source of Income	Payment Amount	Weekly or monthly	Payment Coverage (mm/dd/yyyy)	
☐	Sick Pay	$	☐ Wkly ☐ Mthly	From:	To:
☐	Salary Continuance	$	☐ Wkly ☐ Mthly	From:	To:
☐	State Disability	$	☐ Wkly ☐ Mthly	From:	To:
☐	Workers' Compensation	$	☐ Wkly ☐ Mthly	From:	To:
☐	Unemployment	$	☐ Wkly ☐ Mthly	From:	To:
☐	Social Security Disability	$	☐ Wkly ☐ Mthly	From:	To:
☐	Disability/Retirement Pension	$	☐ Wkly ☐ Mthly	From:	To:
☐	Other:	$	☐ Wkly ☐ Mthly	From:	To:

6 Certification and signature

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

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

7 Fraud warnings

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

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

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

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

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

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

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

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

DE, ID and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

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

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

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

7 **Fraud warnings**, continued

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

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

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

NM: 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 civil fines and criminal penalties.

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

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

OR Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

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

RI: 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.

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

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

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

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