

# Sun Life Assurance Company of Canada

## Short Term Disability Claim Packet



### Instructions

- Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**
  - Employer Statement
  - Employee Statement
  - Attending Physician Statement
  - Authorization Statements

An STD claim should be submitted for a disability absence that may extend beyond the required elimination period.
- Prefill the Group STD policy number and Employer name on the Employee and Physician Statements.
- Employer is required to include the following (as applicable):
  - Enrollment Form
  - W2
  - Return-to-Work slip
  - Worker Compensation Report
  - Job Description/Occupational Information
  - Payroll Ledger
- Physician must completely fill out and sign the Physician Statement.
- Have all the physicians keep a copy of your signed authorization for their files.

The **employee** should make sure all of the sections are complete including the **Physician Statement**. Then, he or she should mail or fax the completed claim form to:



MGIS  
 111 South Main St., Ste. 400  
 Salt Lake City, UT 84111-2176  
 Tel: 800-969-6447  
 Fax: 800-497-8249

### Employer's Statement

Group STD policy number
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### 1 General Information

Please print clearly.

MGIS  
 111 South Main St., Ste. 400  
 Salt Lake City, UT 84111-2176  
 Tel: 800-969-6447  
 Fax: 800-497-8249

Name of employer (parent company name)		Employer phone number	
Employer street address (employee's location)	City	State	Zip code
Name of employee (first, middle initial, last)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number
Employee street address	City	State	Zip code
Employee phone number Home Work	Preferred form of contact <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Mail		Date of birth

## 2 Employment and Claim Information

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

Attach Return-to-Work slip from physician.

Attach Worker's Compensation Report and Reward/Denial notice.

## 3 Salary and Benefits Information

How was the employee paid? (check one)

<input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried
\$ per hour:	\$ per week:

Other work related income:

Commissions	Bonuses	Overtime
\$	\$	\$

If employee contributes to STD premium, attach a copy of employee enrollment form

How does employee contribute toward the STD premium?

PRE-tax  POST-tax  Employee does not contribute

If employee contributes, please provide percentage. .... %

## 4 Information About Other Income

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 (M/D/Y)	
<input type="checkbox"/> Sick pay	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Salary continuance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> State Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Worker's Compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Unemployment	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Social Security Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:
<input type="checkbox"/> Other:	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From:	To:

## 5 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 (original signature required) X	Date signed

# Sun Life Assurance Company of Canada

## Short Term Disability Claim Packet



### Employee's Statement

Group STD policy number

#### 1 General Information

MGIS  
 111 South Main St, Ste. 400  
 Salt Lake City, UT 84111-2176  
 Tel: 800-969-6447  
 Fax: 800-497-8249

Name of employee (first, middle initial, last)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)	
Employee street address		City	State	Zip code	
Employee e-mail address*					
Home phone:		Preferred form of contact:			
Cell phone:		<input type="checkbox"/> Home phone		<input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone	
Work phone:		<input type="checkbox"/> Mail		<input type="checkbox"/> E-mail	
Name of employer (parent company name)					

\*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 email 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 email message to your email 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 email 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 email 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.

#### 2 Information About the Condition Causing Your Disability

Last day worked before disability	Date first treated by Physician	Date expected to return to work <input type="checkbox"/> FT <input type="checkbox"/> PT
Did you require Emergency Room care for your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Hospital name:		
Date:	Phone:	
Were you confined to a hospital for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, include the hospital name		Hospital phone
Date(s) of confinement: From: To:		

#### Select the appropriate type of condition, and provide details:

<input type="checkbox"/> <b>Pregnancy</b>	
Expected due date:	Actual due date:
Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section	
Complications:	

## 2 Information About the Condition Causing Your Disability continued

<input type="checkbox"/> <b>Work-related injury/sickness</b> Date of first symptom/injury: Where occurred: Cause of injury/sickness: Do you intend to file for Workers Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the status: <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Appealed
<input type="checkbox"/> <b>Sickness</b> First date of symptom: Type of sickness: Have you experienced a symptom in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:
<input type="checkbox"/> <b>Motor vehicle accident</b> - complete only if applicable *Please provide a copy of the MVA/Police Report.  Date occurred: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Was a citation issued to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of citation:  How injury occurred: Where injury occurred:  Name of your car insurance carrier: Phone number:  Are you receiving compensation from a car insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: From: _____ To: _____
<input type="checkbox"/> <b>Other injury</b> Date occurred: _____ Where occurred: How occurred: Describe type of injury:

## 3 Information About Other Income

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

<input type="checkbox"/> Sick pay/Salary continuance <input type="checkbox"/> State Disability <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other:
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## 4 Physician Information

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

Name of physician:	Phone:
Specialty:	Fax:
Name of physician:	Phone:
Specialty:	Fax:

## 5 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
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# Sun Life Assurance Company of Canada

## Short Term Disability Claim Packet



### Attending Physician's Statement

Group STD policy number

#### 1 Information About the Patient

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

MGIS  
111 South Main St., Ste. 400  
Salt Lake City, UT 84111-2176  
Tel: 800-969-6447  
Fax: 800-497-8249

Name of patient (first, middle initial, last) <input type="checkbox"/> M <input type="checkbox"/> F	Social Security number	Date of birth (m/d/y)	
Name of employer (parent company name)			
Patient home street address	City	State	Zip code
Patient home phone number	Patient work phone number		

#### 2 Physician Information

- Complete all sections – any missing information may result in a delay to your patient
- Print clearly
- Fax this form to 800-497-8249 or as instructed by patient

Name of attending physician (first, middle initial, last)	Specialty	Tax ID#	
Street address	City	State	Zip code
Phone number	Fax number		

List other physicians treating for this condition

Name of physician: Specialty:	Phone: Fax:
Name of physician: Specialty:	Phone: Fax:

#### 3 Diagnosis and History

Your response is required and affects the patient's benefit. Failure to complete this information may cause the patient financial hardship due to lack of benefit payments.

Primary Diagnosis (include any complications)	ICD-9 Code
Secondary Diagnosis (if applicable)	ICD-9 Code
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date occurred:	
If pregnancy, provide the following: Expected delivery date:      Actual delivery date:	Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section
List any complications pre or post delivery that would extend this disability longer than a normal pregnancy.	
Is condition due to injury/sickness arising out of patient's employment?... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Describe objective or abnormal findings and date.

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

<input type="checkbox"/> X-ray <input type="checkbox"/> EKG <input type="checkbox"/> MRI <input type="checkbox"/> PFT <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other data (e.g. Labs)
Date(s):
Findings:

#### 4 Treatment Details

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 condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of hospital	Date	Phone number	

Check all that apply and describe type, frequency and treatment

<input type="checkbox"/> Surgery	<input type="checkbox"/> Medications prescribed	<input type="checkbox"/> Therapy	<input type="checkbox"/> Behavioral intervention	<input type="checkbox"/> Other
Date(s):				
Procedure/Treatment:				
Is patient:	<input type="checkbox"/> Hospital confined	Date from:	Date to:	
	<input type="checkbox"/> House confined	<input type="checkbox"/> Bed confined	<input type="checkbox"/> Ambulatory	
Hospital name:			Phone:	

#### 5 Restrictions and Limitations

Describe what the patient <b>can do</b> .	From: To:
Describe what the patient <b>should not do</b> .	From: To:
Is patient capable of working with these restrictions/limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Full-Time: 8+ hours/day	<input type="checkbox"/> Part-Time: _____ hours/day

Indicate class of impairment - As defined in federal dictionary of occupation titles

##### Physical Impairment

<input type="checkbox"/> Class 1 – No limitation	<input type="checkbox"/> Class 4 – Moderate limitation
<input type="checkbox"/> Class 2 – Slight limitation	<input type="checkbox"/> Class 5 – Severe limitation
<input type="checkbox"/> Class 3 – Medium limitation	

##### Mental Impairment (if applicable)

##### Current DSM diagnosis

<input type="checkbox"/> Class 1 – No limitation	
<input type="checkbox"/> Class 2 – Slight limitation	
<input type="checkbox"/> Class 3 – Moderate limitation	
<input type="checkbox"/> Class 4 – Marked limitation	
<input type="checkbox"/> Class 5 – Severe limitation	
Do you believe this patient is competent to endorse/direct the use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No	

#### 6 Return-to-Work

Indicate the specific date or recovery period for when the patient will recover sufficiently to perform duties.

<ul style="list-style-type: none"> <li>Return to patient's occupation full-time: Date: _____ -or-  <input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input type="checkbox"/> 5-6 wks <input type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks  <input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____ <input type="checkbox"/> Never</li> </ul>
<ul style="list-style-type: none"> <li>Return to patient's occupation part-time: Date: _____ -or-  <input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input type="checkbox"/> 5-6 wks <input type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks  <input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____ <input type="checkbox"/> Never</li> </ul>

#### 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.

Attending Physician Signature (original signature required) X	Date
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# Sun Life Assurance Company of Canada

## Short Term Disability Claim Packet



### Fraud Warnings

State law requires that we notify you of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## 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 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 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) 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; (b) my treating physicians, psychologists and therapists/counselors; (c) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (d) my insurer, if the Company is acting only as the administrator of my claim and; (e) 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, 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 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, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada (“the Company”), its subsidiaries, affiliates, third party administrators and 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) 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; (b) my treating physicians, psychologists and therapists/counselors; (c) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (d) my insurer, if the Company is acting only as the administrator of my claim and; (e) 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, 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	Claimant date of birth (mm/dd/yyyy)
Signature of employee or personal representative X	Date signed (mm/dd/yyyy)

## Authorization for Release and Disclosure of Non-Health Related Information

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

I understand that the Company 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) 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; (b) my treating physicians, psychologists and therapists/counselors; (c) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (d) my insurer, if the Company is acting only as the administrator of my claim and; (e) 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, 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 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)

## **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. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-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 and
- 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, and
- comply with federal, state or local laws, respond to a subpoena or comply with an injury 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, and
- 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 Short Term Disability Claims  
P.O. Box 81915  
Wellesley Hills, MA 02481