Sun Life and Health Insurance Company (U.S.)
Life benefits claims packet - Employee

Use this claims packet for the following:

- waiver of premium benefits—totally disabled without further premium payments
- accelerated benefits—terminal illnesses and qualifying events
- accidental dismemberment benefits—accidental bodily injury or loss
- permanent total disability benefits—permanently and totally disabled

Do not use this claims packet for death claims. Instead, use the Sun Life and Health Insurance Company (U.S.) death claims packet – Employer Statement (GLFM-7552 (NY)) and Claimant Statement (GLFM-7551 (NY)).

Instructions for the employee

In the event of illness, dismemberment, or disability of an insured, please follow these steps as soon as you determine whether the insured is eligible for accelerated benefits, waiver of premium benefits, permanent total disability benefits and/or accidental dismemberment benefits.

1. The claimant completes the employee's statement and authorizations and collects the following:
   - ☐ a copy of all medical records from date of disability/loss to present
   - ☐ a copy of a government issued photo I.D.

2. **The employee must**:
   - ☐ sign and date the employee's statement
   - ☐ sign and date the authorizations
   - ☐ have the employer complete and return the employer's statement to Sun Life Financial
   - ☐ have the physician complete and return the attending physician's statement to Sun Life Financial

   It is the responsibility of the employee to ensure that the employer's statement and the attending physician statement are submitted directly to Sun Life Financial.

3. **Please send all claim paperwork to:**

   Sun Life and Health Insurance Company (U.S.)
   Group Life Claims
   P.O. Box 81365
   Wellesley Hills, MA 02481
   Tel: 800-247-6875
   Fax: 888-551-2084

Failure to provide complete and accurate information could result in the need for an additional claims investigation, which could delay the initial benefit payment or the approval of the waiver of premium.

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Life benefits claims packet - Employee

Employee's statement

It is the responsibility of the employee to ensure that the employer's statement and the attending physician's statement are submitted directly to Sun Life Financial.

1 General information

Please print clearly.

Employee's name (first, middle initial, last) ☐ M ☐ F		Social Security number	Date of birth (m/d/y)
Employee's home address	City	State	Zip code
☐ Single ☐ Married ☐ Widowed ☐ Divorced	Occupation	Telephone number	
Employer's name		Group policy number	

2 Information about the disability/loss

Please print clearly.

*You may elect to receive up to 75% of your group life insurance benefit once during your lifetime, subject to your plan maximum. Benefits may vary by state and by contract.

What was the date of your accident or when did you first notice symptoms of your illness (m/d/y)?	
Describe how, when, and where the accident occurred or the nature of your illness and its first symptoms.	
For accidental dismemberment only—please state the date and nature of your loss.	
For accelerated benefits only —write in the amount you are requesting"	
Have you previously filed for or received an Accelerated Benefit under the group policy? ☐ Yes ☐ No	
Benefit applied for: ☐ Terminal Illness ☐ Other qualifying event (as defined by your policy). If "other", describe present medical condition:	
Date you were first treated by a physician	Date last worked prior to disability
Have you returned to work? ☐ Yes ☐ No If yes, give date:	Did you work a full day? ☐ Yes ☐ No

3 Information about physicians and hospitals

Please provide the names and addresses of all physicians you have seen for this condition.

If you need more space, attach additional pages.

Physician's name	Physician's phone number
Address	
Specialty	Date of treatment

Physician's name	Physician's phone number
Address	
Specialty	Date of treatment

3 Information about physicians and hospitals, continued

Please provide this information if you have been hospital-confined for this condition.

If you need more space, attach additional pages.

Name of hospital	Date of confinement
Address	

Name of hospital	Date of confinement
Address	

4 Information about your training, education, and experience

Complete this section if this is a waiver of premium claim.

Please attach a copy of your resume, if applicable.

What is your level of education?

☐ Grade school ☐ High school ☐ Trade school ☐ College

☐ Other course (please specify) _____

List all previous occupations and the dates worked for each employer.

Employer's name	Dates of employment	Occupation/type of work

5 Information about Social Security disability benefits

Have you applied for Social Security? ..... ☐ Yes ☐ No

If "yes," what is the status of your application?

☐ Pending ☐ Approved ☐ Denied ☐ Other: _____

6 Signature

Reminder: Please be sure to sign and return any authorization statements included in this packet.

Receipt of accelerated death benefits may affect your eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or the eligibility of your spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.

This application is voluntary and without coercion on the part of any third party.

No health care facility as defined in section 20 of the Public Health Law can require you to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

Remaining death benefits, if any, will be available to the beneficiary.

The insurer is prohibited from paying accelerated death benefits to you for a period of 5 days from the date a numeric illustration is transmitted in writing to you.

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

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee's signature X	Date signed

Sun Life and Health Insurance Company (U.S.)
Life benefits claims packet - Employee

Authorization

Authorization for release and disclosure of health-related information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

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 and Health Insurance Company (U.S.) ("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 and Health Insurance Company (U.S.), 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)

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 and Health Insurance Company (U.S.) ("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 and Health Insurance Company (U.S.), 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)

Sun Life and Health Insurance Company (U.S.)
Life benefits claims packet - Employee

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 and Health Insurance Company (U.S.) ("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 and Health Insurance Company (U.S.), 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 and Health Insurance Company (U.S.)
Wellesley Hills, MA 02481
800-247-6875

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life and Health Insurance Company (U.S.) ("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 and Health Insurance Company (U.S.)
Group Life Claims
P.O. Box 81365
Wellesley Hills, MA 02481