Sun Life Financial®

Dear Employee,

As required by the group insurance policy, you must complete the attached Statement of Insurability Health Questionnaire, and your application must be approved by Sun Life Assurance Company of Canada before the coverage you elected is effective. Please respond to all questions in the application.

After you have completed the Statement electronically print out a copy for your records. If you wish you may mail the Statement to the plan administrator designated by your employer at the following address:

Western Insurance Specialties, Inc.
P.O. Box 12910
Reno, NV 89510

Thank you.

Sun Life Assurance Company of Canada

Evidence of Insurability Application – Health Questionnaire

Sun Life Financial®

- You are applying for coverage from the company above, outside of New York, which is referred to as "The Company" on this application.
- Complete and return the entire application and the instructions page to Sun Life Assurance Company of Canada.

1 Employee information (Please print clearly)

Employer name			Group policy number 907113
Employee name (first, middle initial, last)			
Employee street address	City	State	Zip code
Social Security number – –	Daytime phone number	Evening phone number	
E-mail address	Occupation		

2 Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by The Company. No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

	First name	Last name	DOB (mm/dd/yyyy)	Height	Weight	Gender
Employee						☐ M ☐ F
Spouse/ partner						☐ M ☐ F

In the past five years, have you or your spouse/partner ever been diagnosed with or treated for:	Employee Yes	Employee No	Spouse/partner Yes	Spouse/partner No
1. Any disease or disorder of the heart, kidneys, liver or lungs, cancer or other tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder or are you currently taking any medication prescribed by a physician or other practitioner?	☐	☐	☐	☐
2. Consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?	☐	☐	☐	☐

3 Details (provide details below for all questions answered "yes.")

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question number	Applicant name	State and provide details for each condition and activity	Date condition began	Duration of condition and treatment	Physician name, address and phone number	Fully recovered?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Please provide physician information even if you answered "no" to all the questions.

Name and address of physician with your most up-to-date and comprehensive medical records:

4 Acknowledgement, authorization for release and disclosure of health related information and signature

Acknowledgement

I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- This application and all information related to it may be disclosed, by me or by The Company, to my Employer or the plan administrator designated by my Employer.

If I have any questions regarding my EOI Application, I can write to Sun Life Financial, Group Medical Underwriting, PO Box 81344, Wellesley, MA 02481.

4 Acknowledgement, authorization for release and disclosure of health related information and signature, continued

I AUTHORIZE any physician, health care 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 Medical Underwriting 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 that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that 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 does not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Medical Underwriting, PO Box 81344, Wellesley, MA 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.

Signature of employee X	Date signed
Signature of spouse/partner (If application is for spouse/partner) X	Date signed

5 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.]

Contact us

[www.sunlife.com/us]

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