Sun Life Assurance Company of Canada

Critical Illness Claim Statement

1 Instructions

The following benefits, subject to the election of your employer, may be covered under your Certificate. See the Certificate for the list and definition of benefits. You will need to submit your claim using the mail, fax, and/or e-mail information found on the last page under the “Contact Us” section.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

1. Complete Sections 3, 4a and 6 if filing for the insured
2. Complete Section 3, 4b or 4c and 6 if filing for a dependent
3. Have the physician complete Section 7
4. Sign and date the Authorization sections
5. Provide documentation:

Attach medical documentation to support your claim for Critical Illness benefits. Some of the documentation can be obtained by requesting a copy of the medical records, hospital records, hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider. See Part 7 for detail of initial medical records to submit.

Wellness Screening Benefit: See policy for covered tests or procedures. If submitting a claim for this benefit use the Wellness Claim Statement (Form GCIFM-7261).

2 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, 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.

2 **Fraud warnings,** continued

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.

3 General information

Policyholder/employer name	Policyholder number	Phone number
Street address	City	State	Zip code

4 Patient information

Claiming benefits for: ☐ Insured ☐ Spouse ☐ Dependent

4a. Insured:

Insured employee name (As it appears on your Social Security card)			☐ Male ☐ Female
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			
Social Security number	Date of birth (mm/dd/yyyy)	Home phone number	Mobile phone number
E-mail address			
Street address	City	State	Zip code

Did injury/illness result from employment?..... ☐ Yes ☐ No ☐ Currently disputed

4b. Spouse:

Spouse name (As it appears on your spouse's Social Security card)		☐ Male ☐ Female
Social Security number	Date of birth (mm/dd/yyyy)	Mobile phone number

Did injury result from employment? ..... ☐ Yes ☐ No ☐ Currently disputed

4c. Dependent:

Dependent name (As it appears on your dependent's Social Security card)		☐ Male ☐ Female
Social Security number	Date of birth (mm/dd/yyyy)	Mobile phone number

Did injury result from employment? ..... ☐ Yes ☐ No ☐ Currently disputed

5 Signature

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

If I receive a critical illness benefit greater than that which I should have been paid, I understand that Sun Life Assurance Company of Canada has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

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)

If claimant is a minor, the employee should sign.

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

6 Claim information

Benefits payable are determined by the policy. All conditions listed may not be in your particular policy. See policy for details.

Primary physician name		Phone number	
Street address	City	State	Zip code

Provide the following information of any treating physicians.

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

For services related to a hospitalization, please provide the following.

Name of hospital			
Street address	City	State	Zip code
Admission date (mm/dd/yyyy)	Discharge date (mm/dd/yyyy)		

7 Physician's Statement information

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

	Condition	Medical Documentation Needed - Additional medical information may be requested
☐	Benign Brain Tumor	Hospital discharge summary, pathology report, and current assessment to address any persistent neurological deficits. Neurological treatment records to include diagnostic test results and neurological exam findings.
☐	Complete blindness	Ophthalmologist's report with visual acuity and visual fields at onset and six months post onset
☐	Coma	Hospital records and test results at onset and one week post event
☐	Complete loss of hearing	Audiogram testing results with documented decibel hearing loss.
☐	End-stage Kidney Disease	Physician or dialysis center report of regular hemodialysis and/or peritoneal dialysis for longer than 90 days and chronic and irreversible kidney failure
☐	Loss of Speech	Speech evaluations at onset date and six months post onset date
☐	Major Organ Failure	Proof of listing with United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP)
☐	Occupational Infectious Diseases	• Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation; • A negative antibody for HIV (or Hepatitis B, C and/or D) test, performed by a state certified and licensed laboratory within five days of exposure; and • A positive antibody for HIV (or Hepatitis B, C and/or D) test, taken in the 90 to 180 days following the exposure.
☐	Paralysis	Initial hospital discharge summary and assessment at 6 months post onset
☐	Severe Burns	Hospital admission/discharge summaries and medical documentation the specifies degree and size of burns
☐	Stroke	Neuroimaging studies, hospital discharge summary, and current assessment

ALS/Alzheimer's/Parkinson's

☐	Advanced ALS/Lou Gehrig's Disease*	Documentation of diagnosis by a physician. Requires either a feeding tube or non-invasive ventilation.
☐	Advanced Alzheimer's Disease*	Documentation of diagnosis on the FAST Staging Scale (Stage 6 or higher) related to Alzheimer's related dementia by a qualified medical provider. Current assessment documenting neurological impairments.
☐	Advanced Parkinson's Disease*	Documentation of primary idiopathic Parkinson's disease at stage 4 or higher on the Hodhn/Yahr scale by a qualified neurologist. Neurologist evaluation addressing current physical examination/condition.

*Also requires that the claimant is unable to perform 3 or more of the following activities of daily living: bathing, dressing, toileting, transferring, continence or eating.

Heart

☐	Angioplasty	Surgical report and hospital discharge summary
☐	Coronary Bypass Surgery	Surgical report and hospital discharge summary
☐	Heart Attack	Cardiac enzyme and biomarkers, Electrocardiogram (EKG), Thallium scans, MUGA scans, Stress echocardiogram, hospital discharge summary, and cardiac catheterizations
☐	Heart Failure	Proof of listing with United Network of Organ Sharing (UNOS)

Cancer

☐	Cancer in situ	Pathology report
☐	Invasive Cancer	Pathology report, operative report (if available), and laboratory records
☐	Skin Cancer	Pathology report documenting evidence of basal cell or squamous cell cancer of the skin.

7 **Physician's Statement information**, continued

Child-Specific Critical Illness

	Condition	Medical Documentation Needed - Additional medical information may be requested
☐	Cerebral Palsy	Medical assessment by a physician confirming the diagnosis of cerebral palsy and documentation of developmental delays, physical findings, posture abnormalities, and any intellectual or behavioral difficulties.
☐	Cleft Lip/Palate	Current assessment from a physician documenting the cleft lip or cleft palate by routine examination.
☐	Complex Congenital Heart Disease	Treatment notes from treating specialist(s) form date of diagnosis to at least two months post diagnosis to include appropriate diagnostic test results and laboratory reports.
☐	Cystic Fibrosis	Sweat chloride test and genetic testing confirming cystic fibrosis.
☐	Down Syndrome	Genetic testing (chromosome study) which confirms the diagnosis of Down Syndrome.
☐	Muscular Dystrophy	Diagnosis of either Duchenne or Becker muscular dystrophy with confirmation by CPK blood test, muscle biopsy, electromyography and genetic testing.
☐	Spina Bifida	Current assessment documenting the diagnosis of spina bifida either by diagnostic testing (x-ray, MRI, CT) or by routine examination.
☐	Type I Diabetes Mellitus (DM)	Fasting blood glucose testing, oral glucose tolerance testing, hemoglobin A1C lab testing. Current assessment from the treating physician describing diagnosis and lab results. Must be on insulin therapy.

Date symptoms first appeared (mm/dd/yyyy)	Date diagnosis made or date of related procedure (mm/dd/yyyy)	ICD Code

Are any of the following a contributing factor in the condition? (Check all that apply)

☐ Use of drugs ☐ Committing a felony ☐ Intoxication ☐ Self-inflicted ☐ Attempted suicide

Has this patient been treated for this condition or a similar condition prior to this occurrence? ..... ☐ Yes ☐ No

If, "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.

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

Physician's information

Name of attending physician (first, middle initial, last)	Degree	Specialty/Board certification	
Street address	City	State	Zip code
Phone number	Fax number		

Physician – 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	Date (mm/dd/yyyy)
X	

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 or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

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

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I 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 or leave program in which I participate, (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 Financial, Group Critical Illness Claims, One Sun Life Executive Park, SC5500, 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	
Signature of claimant or personal representative X	Date (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 or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., Social Security Administration, Internal Revenue Service or the Veteran's Administration, to disclose to Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and reinsurers, any and all non-health information relating to me, including, but not limited to (a) my employment earnings; (b) my occupational duties; (c) my credit history; (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I, or my dependents, may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that the Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

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 or leave program in which I participate, (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 Financial, Group Critical Illness Claims, One Sun Life Executive Park, SC5500, 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	
Signature of claimant or personal representative X	Date (mm/dd/yyyy)

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
877-820-5306

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

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

- Physicians, healthcare providers, medical professionals, hospitals, clinics or other medical or healthcare related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose
such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

Contact us

By mail
Sun Life Assurance Company of Canada
300 Southborough Drive, STE 200
South Portland, ME 04106-6914

By fax
866.376.9480

By e-mail
slfworksiteclaims@disabilityrms.com

www.sunlife.com/us

Customer Service **877-820-5306** M–F 8:00 a.m. – 5:00 p.m., ET