Sun Life Assurance Company of Canada
Short Term Disability Claim Packet - Claimant

Instructions

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

Please be sure to submit the Claimant's Statement directly to Sun Life Financial.

The Claimant must:

☐ 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
- Claimant Statement
- Attending Physician Statement
- Authorization Statements

An STD claim should be submitted for a disability absence that may extend beyond the required elimination period.

☐ Have the physician completely fill out and sign the Physician Statement.

☐ Have all the physicians keep a copy of your signed authorization for their files.

To file a Disability Claim or check on a status online go to www.sunlife.com/us.

- Click on "Submit a Disability Claim"
- OR **Fax to: 781-304-5599**
- OR **e-mail to:** myclaimdocuments@sunlife.com

Sun Life Assurance Company of Canada
Short Term Disability Claim Packet - Claimant

Claimant's Statement

Group STD policy number

1 General Information

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

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

2 Information About the Condition Causing Your Disability

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

Select the appropriate type of condition, and provide details:

☐ **Pregnancy**
Expected due date: Actual due date:
Delivery type: ☐ Normal ☐ C-Section
Complications:

☐ **Work-related injury/sickness**
Date of first symptom/injury:
Where occurred:
Cause of injury/sickness:
Do you intend to file for Workers Compensation? ☐ Yes ☐ No
If yes, what is the status: ☐ Denied ☐ Approved ☐ Pending ☐ Appealed

☐ **Sickness** First date of symptom:
Type of sickness:
Have you experienced a symptom in the past? ☐ Yes ☐ No Date:

2 Information About the Condition Causing Your Disability continued

☐ **Motor vehicle accident*** - complete only if applicable.
*Please provide a copy of the MVA/Police report.

Date occurred: Time: ☐ AM ☐ PM
Was a citation issued to you? ☐ Yes ☐ 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? ☐ Yes ☐ No
If yes, Date: From: To:

☐ **Other injury**
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?

☐ Sick pay/Salary continuance ☐ State Disability ☐ Worker's Compensation
☐ Other:

4 Physician Information

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

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

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.

Fraud Warnings continued

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 knowing 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.

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 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	
Signature of claimant or personal representative X	Date (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	
Signature of employee or personal representative X	Date

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 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	
Signature of claimant or personal representative X	Date (mm/dd/yyyy)

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
(800) 247-6875

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

Sun Life Assurance Company of Canada

Direct Deposit Authorization

To enjoy the safety and convenience of Sun Life Financial's direct deposit services, simply complete this form and return it to your Sun Life Financial representative.

Important: To verify your bank and financial information, attach a **void check** or **a signed letter from your bank on their letterhead**. **We cannot set up direct deposit services without this information.**

1 Insured information (please print clearly)

Name of insured/employee		Policy number
Street address		
City	State	Zip code
Name of authorized representative signing this form (if applicable)	Title	Phone number

2 Financial institution

Remember to attach a **void check** or **signed letter from your bank on their letterhead** to verify the bank or financial institution information you provide below. **We cannot set up direct deposit services without this information**.

Name of bank or financial institution	City and state of bank or financial institution
Insured/employee's account number at bank or financial institution	Bank or financial institution routing number

3 Insured authorization statement

I hereby authorize Sun Life Assurance Company of Canada, including any of its subsidiaries and affiliates, to make all payments due under the policy listed above by direct deposit to the account designated above. This authorization shall be effective until further written notice from me, or another legally authorized representative, is received by Sun Life Assurance Company of Canada.

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

Signature of insured/employee X	Date (mm/dd/yyyy)

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

Contact us

By mail
Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

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

By e-mail
myclaimdocuments@sunlife.com

www.sunlife.com/us

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

Sun Life Assurance Company of Canada

Third Party Authorization - Group Short-Term Disability Claims

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

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

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

1 Authorized person(s)

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

Name	Relationship to employee	Name	Relationship to employee

2 Signature(s)

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

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

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

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

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

Contact us

By mail
Sun Life Assurance Company of Canada
Group Short-Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481

By fax
781-304-5599

By e-mail
myclaimdocuments@sunlife.com

www.sunlife.com/us

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