Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

EVIDENCE OF INSURABILITY

ANSWER ALL QUESTIONS COMPLETELY - PLEASE PRINT LEGIBLY

Name of Employee (Last, First, M.I.)	Social Security Number	Employee's Occupation (Title)	Group Policy Number

Residence (No., Street, City, State, Zip Code)

Gender ☐ Male ☐ Female	Date of Birth (Mo., Day, Yr.)	Home Phone Number	Work Phone Number	E-Mail Address

Name of Firm	Firm Address (No., Street, City, State, Zip Code)

Reason for Evidence of Insurability ☐ Late Applicant ☐ Late Dependent Coverage ☐ Adding New Dependent
☐ Amount over Non-Med Issue ☐ Salary Increase/New Salary _____ per _____

HEALTH STATEMENT – Must be completed in its entirety.

The questions that follow must be answered for each employee and dependent requesting coverage. Failure to provide complete responses may result in underwriting delays, rescission of coverage and/or non-payment of claims. This request for coverage is not effective until approved by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)). No information provided by you to your agent shall bind SLHIC (U.S.) unless you also provide such information in writing on this form. No agent or broker has the authority to alter the contents of this form.

	YES	NO	Please answer questions 1-9 for you and all your dependents: For the past 10 years.
1.	☐	☐	Have you or any dependents ever had or been told that you/they had elevated blood pressure, chest pain, heart murmur, circulatory or other heart disorder; blood, pus or sugar in the urine, diabetes, kidney, liver or bladder disorder, OB/GYN disorder including diagnosis of or treatment for infertility, any sexually transmitted disease or disorder excluding the Human Immunodeficiency Virus (HIV), blood disorder, immunological disease or disorder excluding HIV, cancer or tumor, ulcer or other gastrointestinal disorder, disorder of the neck, back or knees, epilepsy or severe headache, asthma or respiratory disorder, mental, emotional or nervous disorder or alcoholism?
2.	☐	☐	Have you or any dependent ever been diagnosed or treated for AIDS-related complex (ARC) or acquired immune deficiency syndrome (AIDS)?
3.	☐	☐	Have you or any dependents experienced unexplained persistent diarrhea, unexplained unintentional weight loss, night sweats or persistent swollen glands?
4.	☐	☐	Have you or any dependents been hospitalized, had surgery, taken medication regularly or at frequent intervals or been treated by a physical or psychological health care practitioner for anything other than preventive care?
5.	☐	☐	Have you or any dependents ever been told you/they had chemical dependency, substance use, abuse and/or dependency, ever used narcotics, barbiturates, amphetamines, hallucinogens, or other drugs except as prescribed by a physician?
6.	☐	☐	Are you or any of your dependents currently pregnant? If yes, give due date _____
7.	☐	☐	Have you or any dependents used any type of tobacco products in the past 36 months?
8.	☐	☐	Have you or any dependents ever been told or had reason to believe that medical, surgical, psychiatric or rehabilitative care may be required during the next 12 months?

9. Employee: Height: _____ Weight: _____
Spouse Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____
Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____
Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____
Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____

Give Details Below for All Questions Answered "Yes." (Use additional sheet if necessary)

Question No.	Name of Person Treated	Nature of Ailment	Date of Onset, Duration and Degree of Recovery	Name and Address of Physician, Practitioner, Hospital or Institution

If there is a history of elevated blood pressure complete the following:

☐ History applies to Employee

List 3 Current Blood Pressure Readings Measured at 5-10 Minute Intervals ① ② ③	Date of Readings	Any Medication? ☐ Yes ☐ No	If "Yes" Name and Dosage

☐ History applies to Spouse

List 3 Current Blood Pressure Readings Measured at 5-10 Minute Intervals ① ② ③	Date of Readings	Any Medication? ☐ Yes ☐ No	If "Yes" Name and Dosage

Please make sure you read and sign the back of this form.

Authorization to Obtain and Disclose Protected Health Information

To the best of my knowledge all information shown above is correct and I have read this form.

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, insurance or reinsurance company, to disclose or furnish to **Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.))** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to **records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, Acquired Immune Deficiency Syndrome (AIDS)** or information relating to alcohol or drug abuse if a specific authorization form for release of this information is obtained or mental health care to the extent permitted by law.

I authorize SLHIC (U.S.) to use or disclose this protected health information, in connection with payment or health care operations, to the Health Claim Index (HCI), any reinsurer, and any person or entity performing a business or legal function on behalf of SLHIC (U.S.) or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a request for insurance coverage; (2) my refusal to sign this authorization may result in an application being denied; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date
Signature of Spouse	Date

Access to Personal Information

-Personal information may be collected from persons other than the individual or individuals proposed for coverage. Such information as well as other personal or privileged information subsequently collected by the insured institution or agent may in certain circumstances be disclosed to third parties without authorization. You have the right to see your personal -records and correct personal information collected. You will be furnished with our detailed Description of Information Practices form (XGR/2015) upon request from either the firm administrator and/or the Home Office.

California Notice

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraudulent Insurance Act – WARNING

WARNING
STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:

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 (in Oregon, "may be guilty of insurance fraud,") commits a fraudulent insurance act, which (in Oregon, may be subject to prosecution.") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN FLORIDA: "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."

IN LOUISIANA: "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."

IN NEW JERSEY: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

IN NEW YORK: "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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation." THIS NOTICE DOES NOT APPLY TO AN APPLICATION FOR LIFE INSURANCE.

IN PUERTO RICO: "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than $5,000 nor more than $10,000, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years. "