Sun Life Insurance and Annuity Company of New York
Life and Disability Claim Packet

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

Use this claim packet for:

- Waiver of Premium Benefits
- Accelerated Benefits
- Accidental Dismemberment Benefits
- Permanent Total Disability Benefits

Do not use this claim packet for Death claims. Instead use the Sun Life Insurance and Annuity Company of New York Death Claim Packet (XNYGR/1550).

Instructions for the Plan Administrator

In the event of an illness, dismemberment or disability of an insured, please follow these steps as soon as you determine that the insured is eligible for Accelerated Benefits, Waiver of Premium Benefits, Permanent Total Disability Benefits and/or Accidental Dismemberment Benefits.

1. Complete the Employer's section of this claim packet and collect the following:
   - ☐ a copy of any and all enrollment forms
   - ☐ a copy of the most recent beneficiary designation on file
   - ☐ a copy of the most recent payroll record

2. The claimant completes the Claimant's Statement and Authorizations and collects the following:
   - ☐ a copy of all medical records from date of disability/loss to present

3. The physician completes the Attending Physician Statement section

4. **The employee collects all completed sections and additional required information and submits the entire packet to:**

   Sun Life Insurance and Annuity Company of New York
   Group Life Claims, SC 3225
   One Sun Life Executive Park
   P.O. Box 81100
   Wellesley Hills, MA 02481
   Tel: 1-800-247-6875

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

Sun Life Insurance and Annuity Company of New York
Life and Disability Claim Packet

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Section A: Employer's Statement

1 General Information

Please print clearly.

Employer's name		Group policy number	Class
Employer contact (name of person completing this form)		Title	
Employer's street address	City	State	Zip Code
Employer's email address	Telephone number	Fax number	
Name and address of Division where employee works			

2 Employee Information

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

3 Dependent Information

Complete only if submitting a Dependent claim.

Dependent's name (first, middle initial, last) ☐ M ☐ F	Date of birth (m/d/y)	Relationship to employee

4 Employment and Claim Information

Type of Claim
☐ Waiver of Premium Benefits ☐ Accidental Dismemberment Benefits
☐ Accelerated Benefits ☐ Permanent Total Disability Benefits

Basic Insurance Amount $	Optional Insurance Amount $	Why did employee cease working? ☐ Illness ☐ Leave of Absence ☐ Layoff ☐ Retired

Date of disability or loss (m/d/y)	Date hired (m/d/y)	Effective date of insurance	☐ Still working ☐ Date last worked

5 Salary and Benefits Information

Provide the most recent payroll record.

How was the employee paid? (check one)

☐ Hourly $ per hour:	☐ Salaried $ per year:

Provide information about other income:

Commissions $	Bonuses $	Overtime $

What was the date of the last pay increase?

6 Certification and Signature

I certify that the above statements are true and complete.

Signature of Plan Administrator X	Date signed

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Section B: Claimant's Statement

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 ☐ Widowed ☐ Married ☐ Divorced	Occupation	Telephone number
Employer's Name		Group policy Number

2 Information About the Disability/Loss

***You may elect to receive up to 75% of your Group Life insurance benefit 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 you first noticed 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.*	
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.

Name of Physician	Physician telephone number
Address	
Specialty	Date of treatment

Name of Physician	Physician 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.

Name of Hospital	Date of confinement
Address	

If you need more space, attach additional pages.

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.

What is your level of education?

☐ Grade School ☐ High School ☐ Trade School ☐ College

☐ Other Course (please specify) _____

Please attach a copy of your resume, if applicable.

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

Employer's Name	Dates of Employment	Occupation/Type of Work

5 Important Information Pertaining to Your Application for Accelerated Benefits

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. _____ (initial)

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.

The insurer is prohibited from paying accelerated death benefits to you for a period of 14 days from the date on which the Accelerated Death Benefit Disclosure Statement is sent to you.

Any amount of Group Life Insurance remaining in force at your death will be paid as a Death Benefit to the beneficiary(ies) of record.

6 Disclosure and Signature

I certify that the above statements are true and complete to the best of my knowledge and belief. I have read and understand the Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or any other person files an accident and health 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	Date signed
X	

Section C: 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.

Return to:
Sun Life Insurance and Annuity Company of New York
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy 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 Insurance and Annuity Company of New York ("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, 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/or (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 Group Life Claims Department, Sun Life Insurance and Annuity Company of New York, SC 3225, 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

Authorization for Release and Disclosure of Psychotherapy Notes

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.

Return to:
Sun Life Insurance and Annuity Company of New York
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

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 Insurance and Annuity Company of New York ("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 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/or (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 Group Life Claims Department, Sun Life Insurance and Annuity Company of New York, SC 3225, 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

Authorization for Release and Disclosure of Non-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.

Return to:
Sun Life Insurance and Annuity Company of New York
One Sun Life Executive Park, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care 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 Insurance and Annuity Company of New York ("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.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize the Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim. I further authorize The Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

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. This Authorization shall apply to information relating to my dependents where applicable.

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 Group Life Claims Department, Sun Life Insurance and Annuity Company of New York, SC 3225, 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

Section D: Attending Physician's Statement

1 Information About the Patient

Please print clearly

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Patient's home address	City	State / Zip Code
Name of Employer	Group policy number	Employee phone no.

2 Diagnosis and History

Provide general information about diagnosis, treatment, doctor's notes and history in this section.

Diagnosis including any complications and ICD-9 Codes(s)	
For Accelerated Benefits Only - If the patient has a terminal illness, please indicate the life expectancy: _____ Months ☐ N/A	
Include objective findings (i.e., x-rays, EKGs, MRIs, laboratory data and any other clinical findings) ☐ N/A	
Subjective symptoms ☐ N/A	
Date symptoms first appeared or accident occurred (m/d/y) ☐ N/A	Date disability commenced (m/d/y) ☐ N/A
Patient's Height:	Patient's Weight:

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit ☐ N/A	Date of last visit ☐ N/A	Date of last examination ☐ N/A
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☐ Other (please specify:)		
Description of Treatment		

4 Progress

Patient's progress: ..... ☐ Unchanged ☐ Retrogressed ☐ Improved ☐ Recovered
Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain:		
If patient has been hospital confined, give dates.	From:	To:
Provide name and address of hospital (if applicable)		

5 Limitations

In a normal day, the patient may:

Stand/Walk	☐ None	☐ 1 - 4 hours	☐ 4 - 6 hours	☐ 6 -10 hours
Sit	☐ None	☐ 1 - 3 hours	☐ 3 - 5 hours	☐ 5 -10 hours
Drive	☐ None	☐ 1 - 3 hours	☐ 3 - 5 hours	☐ 5 -10 hours

Patient may use hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Patient may use feet for repetitive movement as in operating foot controls ..... ☐ Yes ☐ No

During the day, is the patient able to:

	67-100%	34-66%	1-33%	0%
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Twist Body	☐	☐	☐	☐
Push	☐	☐	☐	☐
Pull	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Grasp	☐	☐	☐	☐
Reach	☐	☐	☐	☐

Maximum lifting is _____ pounds

Can the employee work an 8 hr. day with the above restrictions? ..... ☐ Yes ☐ No

If not, how many hours could they work with the above restrictions? _____

6 Physical Impairment

☐ Class 1 No limitation of functional capacity; capable of heavy work* .....No Restrictions (0 - 10%)

☐ Class 2 Medium manual activity* ..... (15 - 30%)

☐ Class 3 Slight limitation of functional capacity; capable of light work* ..... (35 - 55%)

☐ Class 4 Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary*) activity ..... (60 - 70%)

☐ Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity .....(75 - 100%)

* As defined in Federal Dictionary of Occupational Titles.

7 Cardiac (if applicable)

Functional Capacity (American Heart Association)

☐ Class 1 (no limitation)	☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation)	☐ Class 4 (complete limitation)

Therapeutic Class (activity)

☐ No restriction	☐ Slight restriction	☐ Marked restriction	☐ Complete restriction

Blood Pressure - Last Visit _____

8 Mental Impairment (if applicable)

- ☐ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitation)
- ☐ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
- ☐ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
- ☐ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
- ☐ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustments (severe limitation)

Do you believe this patient is competent to endorse checks and direct the use of proceeds thereof? ..... ☐ Yes ☐ No

What is the patient's current DSM-IV-R diagnosis?

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

9 Work Capabilities

Is patient capable of working within these limitations? ..... ☐ Full time ☐ Part time
Is patient capable of another occupation on a full-time basis? ..... ☐ Yes ☐ No
Is patient capable of another occupation on a part-time basis? ..... ☐ Yes ☐ No

10 Certification and Signature

Please provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 2 of this packet.

Name of Attending Physician		Degree/Specialty	
Street address	City	State	Zip Code
Tax ID number	Telephone number	Fax number	
Attending Physician Signature X		Date	

Sun Life Insurance and Annuity Company of New York
Wellesley Hills, MA 02481
1-800-247-6875

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Insurance and Annuity Company of New York ("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 upon 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
- 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

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Insurance and Annuity Company of New York
Group Life Claims, SC 3225
One Sun Life Executive Park
P.O. Box 81100
Wellesley Hills, MA 02481

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