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

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

Instructions for the Plan Administrator

An initial claim for Short Term Disability benefits should be submitted when a disability absence has actually begun, and it first appears that the eligible employee's disability will extend beyond the required elimination period. To file a Short Term Disability Claim, prefill Section A: Employer's Statement. Then, provide the entire claim packet to the employee. The employee should make sure all of the sections are complete including the Physician Statement. Then, he or she should mail or fax the completed claim form to:

Sun Life Insurance and Annuity Company of New York
Group Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel: 1-800-247-6875
Fax: (781) 304-5599

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

Section A: Employer's Statement

1 General Information

Please print clearly.

Name of employer		**Group policy number**	Class
Name of employee (first, middle initial, last) ☐ M ☐ F		Social Security number	Date of birth
Name and address of Division where employee works			Employee phone no.

2 Employment and Claim Information

Be sure to include all salary information.

Date hired (m/d/y)	Effective date of insurance	Date last worked	Hours worked last day
Job title / Major job duties (Or, attach employee's formal job description)			
Regularly scheduled work week: Days per week: Hours per day:		How long had employee been in occupation? Years: Months:	
Has the employee's employment been terminated? ☐ Yes ☐ No		If yes, provide termination date	
Why did employee cease working?			

2 Employment and Claim Information continued

How would you classify this employee's occupation?
☐ Sedentary (1-10 lbs) ☐ Light (11-20 lbs) ☐ Medium (21-50 lbs) ☐ Heavy (51+ lbs)

Is the condition due to an injury or sickness arising out of employee's job?.... ☐ Yes ☐ No ☐ Disputed

Has a Workers' Compensation claim been filed? ..... ☐ Yes ☐ No
If "yes," please include the initial report of illness/injury and award/denial notice with this claim.

Name of your Workers' Compensation carrier:	Phone number
Has employee returned to work? ☐ Yes ☐ No If yes: ☐ With restrictions ☐ Full capacity	Date returned

3 Salary and Benefits Information

Indicate whether or not the employee contributes to the STD premium on a pre- or post-tax basis.

How was the employee paid? (check one)

☐ Hourly	☐ Salaried
$ per hour:	$ per week:

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

Does employee contribute toward the STD premium? ..... ☐ Yes ☐ No

- If "yes," attach a copy of employee's enrollment form to this claim and indicate percentage contribution.....

Employee: %	Employer: %

- Are employee contributions made with pre-tax dollars?..... ☐ Yes ☐ No

4 Information About Other Income

Check all that apply and provide details for each source of income.

Is employee currently receiving, or entitled to receive, benefits from any of the following sources?

	Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐	Vacation pay	$	☐ Wkly ☐ Mthly	
☐	Sick pay	$	☐ Wkly ☐ Mthly	
☐	State Disability	$	☐ Wkly ☐ Mthly	
☐	Other:	$	☐ Wkly ☐ Mthly	

5 Certification and Signature

Tip: To certify eligibility, mail or fax the employee's enrollment form with the claim.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 6 of this packet.

Name of person completing this form	Telephone number	E-mail address
Signature X	Title	Date signed

For more information about Short Term Disability, the claim process and the status of your employees' claims, log onto CustomerLink at https://customerlink.sunlife-usa.com

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Section B: Employee's Statement

1 General Information

Provide your full address and Social Security number.

Please print clearly

Your name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth
Your street address	City	State / Zip Code
Your occupation	Telephone Number	
Employer Name	Group Policy Number	

2 Information About the Condition Causing Your Disability

Reminder: Return completed claim packet (including Attending Physician Statement) and all required documentation to:

Sun Life (N.Y.)
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Tel: 1-800-247-6875
Fax: (781) 304-5599

Type (check one): ☐ Pregnancy ☐ Motor vehicle accident ☐ Work-related injury/sickness ☐ Sickness ☐ Other accident

Describe in detail how, when and where the accident occurred –OR – Describe the nature of your illness/condition and its first symptoms. If work-related, describe cause of injury/illness.		
Date you were first treated by a physician	Last day worked prior to disability	Did you work a full day? ☐ Yes ☐ No
Name of your first treating physician	Physician phone number	
Name of hospital	Hospital phone number	Date(s) of confinement
Date first unable to work	Date you expect to return to work	Do you expect to return full- or part-time? ☐ Full-Time ☐ Part-Time

If work-related, have you filed/do you intend to file, a Workers' Compensation claim?.... ☐ Yes ☐ No

3 Information About Other Income

Check all that apply and provide details for each source of income.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

	Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐	Vacation pay	$	☐ Wkly ☐ Mthly	
☐	Sick pay	$	☐ Wkly ☐ Mthly	
☐	State Disability	$	☐ Wkly ☐ Mthly	
☐	Other:	$	☐ Wkly ☐ Mthly	

4 Signature

Reminder: Please be sure to sign and return any Authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 6 of this packet.

Employee's signature X	Date signed

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Section C: Attending Physician's Statement

1 Information About the Patient

The patient is responsible for any costs associated with the completion of this form.

Please print clearly

Name of Patient (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Name of Employer	Group Policy number	Employee phone no.

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications and ICD-9 Codes(s)	
Objective findings (i.e. x-rays, EKGs, MRIs, laboratory data and any other clinical findings)	
Subjective Symptoms	
Date symptoms first appeared or date of accident	Date Disability Commenced
Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If Yes, when:	
Is condition due to injury/sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown	
Names and telephone numbers of Other Treating Physicians (if applicable)	
If pregnancy, please provide the following information: • Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No	
Describe any complications that would extend this disability longer than a normal pregnancy	

3 Treatment

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

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

4 Progress

Has patient: ..... ☐ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed

Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain:		
Has patient been hospital confined? ..... ☐ Yes ☐ No	From:	To:
If yes, provide name and address of hospital		

Continued on next page

5 Restrictions and Limitations

Restrictions and Limitations should be associated with the Objective and Subjective findings/symptoms noted in section 2.

Restrictions (what the patient should not do)
Limitations (what the patient cannot do)

Is the patient capable of working within these restrictions/limitations? ..... ☐ Yes ☐ No
Can the patient work an eight-hour day with these restrictions/limitations? ..... ☐ Yes ☐ No
If no, how many hours could he/she work? ..... _____ hours
Is patient capable of working in another occupation?..... ☐ Yes - Full-time ☐ Yes - Part-time ☐ No

Indicate class of physical impairment.

* As defined in federal dictionary of occupation titles

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; capable of light work* (35-55%)
☐ Class 4 – Moderate limitation; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation; incapable of minimum (sedentary*) activity (75-100%)

Indicate class of mental impairment.

Mental Impairment (if applicable)

☐ Class 1 – No limitation
☐ Class 2 – Slight limitation
☐ Class 3 – Moderate limitation
☐ Class 4 – Marked limitation
☐ Class 5 – Severe limitation

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

Axis I _____ Axis IV _____
Axis II _____ Axis V _____
Axis III _____

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

6 Return-to-Work

1. When will patient recover sufficiently to perform duties? (Specify date or check recovery period)
   - Patient's occupation part-time:
     Date: _____ **-or-** ☐ < 3 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
   - Patient's occupation full-time:
     Date: _____ **-or-** ☐ < 3 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
2. After reviewing the material and substantial duties of the patient's occupation, would you recommend vocational counseling and/or rehabilitation or job modification? ..... ☐ Yes ☐ No

7 Certification and Signature

Remember to 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 6 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	

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Fraud Warning

State law requires that we notify you of the following:

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 also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 (N.Y.)
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

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, healthcare 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 Sun Life (N.Y.), Group Short Term Disability Claims, SC 3212, 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 (N.Y.)
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

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, healthcare 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 Sun Life (N.Y.), Group Short Term Disability Claims Department, SC3212, 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 Insurance and Annuity Company of New York
Customer Service Center
Wellesley Hills, MA 02481
1-800-247-6975

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 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

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 Short Term Disability Claims
P.O. Box 81915
Wellesley Hills, MA 02481