

# Sun Life Assurance Company of Canada

## Evidence of Insurability

### Application and Instructions



#### About Evidence of Insurability

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Please read these Q & A's and the instructions on the next page before completing the Evidence of Insurability Application.

Answers to frequently asked questions:

#### **When does Sun Life Assurance Company of Canada require Evidence of Insurability (also called Proof of Good Health)?**

It varies from policy to policy. However, Evidence of Insurability is usually required when:

- You apply for an amount of coverage higher than the Guaranteed Issue amount
- You are currently enrolled and want to increase coverage
- You decline coverage during your initial eligibility period and then want coverage at a later date, or
- You elect to buy-up LTD/STD (if applicable)

#### **What is the Guaranteed Issue limit?**

If you are an eligible employee and you apply for Group Life and/or AD&D coverage within 31 days of your date of eligibility, then you generally can apply for any amount of coverage, in various increments, up to the coverage maximum. However, the plan only guarantees you a certain amount of coverage – the Guaranteed Issue limit – without having to provide Evidence of Insurability. See your plan booklet, or ask your employer, for your plan's coverage maximum and Guaranteed Issue limit.

#### **What if I apply after 31 days?**

If you apply for coverage past 31 days from your date of eligibility, you will be considered a "late entrant" and the entire amount you are applying for will be subject to Evidence of Insurability.

#### **How do I provide Evidence of Insurability?**

Follow the instructions on the next page. Complete the attached Evidence of Insurability form. Mail or fax to:

Sun Life Financial  
Group Medical Underwriting, SC 7190  
15 Rye Street  
Portsmouth, NH 03801  
Fax: (781) 446-1517

#### **What happens after I submit the Evidence of Insurability Application?**

After we receive your Evidence of Insurability form, Sun Life Assurance Company of Canada may contact you to arrange for you to take a medical exam (at our expense). Coverage will not go into effect until Sun Life Assurance Company of Canada contacts your employer with approval.

# Instructions for completing the Evidence of Insurability Application

## Employer Information:

- The employer should complete this section before providing the form to the employee.
- Be sure to indicate whether the form is for an employee or dependent application.
- Indicate the total amount being requested.
- Please check off the type of application. If it is an increase to a current amount or over the Guaranteed Issue (GI) limit, please indicate the current amount or GI limit.

## Statement of Health:

- Questions apply only to the person applying for coverage.
- Please answer all questions.
- If you answer "yes" to any questions, please provide complete details of the condition, including duration of condition and treatment.
- Questions left unanswered could delay your application.

**Sun Life Assurance Company of Canada**  
Evidence of Insurability Application

**Employee:** Please be sure your employer has completed the shaded box below left. Then, complete all sections below. Complete a separate form for your spouse and/or children only if they are applying for coverage. Read and sign this form on Page 2 (reverse) before submitting it to us. Mail completed form to Sun Life Assurance Company of Canada, Group Life Department, SC 3227, One Sun Life Executive Park, P.O. Box 81100, Wellesley Hills, MA 02481. Questions about this form? Call 1-800-247-6875. **Please print clearly.**

**Employer Use Only:** Please complete the section below before providing this form to the employee.

Group Policy Number: \_\_\_\_\_

Approval Requested For:  
 Employee  
 Dependent(s)

Total Amount Requested:  
 Life Insurance: \_\_\_\_\_  
 Employee Basic \$ \_\_\_\_\_  
 Employee Opt1 \$ \_\_\_\_\_  
 Spouse Opt1 \$ \_\_\_\_\_  
 Child Optional \$ \_\_\_\_\_

Other Coverages  
 LTD  STD  Other: \_\_\_\_\_  
 Amount Requested: \_\_\_\_\_

Type of Application:  
 New Hire (over Guaranteed Issue amount)  
 Late Applicant (previously waived)  
 Qualifying Event (marriage, birth of child, etc.)  
 Please indicate date of event: \_\_\_\_\_  
 Increase coverage. Please indicate prior amount of coverage in-force:  
 Employee: ... \$ \_\_\_\_\_  
 Spouse/Child: ... \$ \_\_\_\_\_

Employer Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

Please complete all applicable sections on Page 2 (reverse). If you answer "yes" to any of the questions at right, please provide details in the space provided on Page 2.

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**Employee Name (first, middle initial, last)** \_\_\_\_\_

Residence Address (street no. and name, apt. or suite) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employee's Home Phone No. \_\_\_\_\_  
 Employee's Phone No. \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ Annual Salary \_\_\_\_\_

Person Applying for Coverage:  Employee  Spouse  Child  Male  Female

Name (first, middle initial, last) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Statement of Health:** If you answer "yes" to any of the questions, please write in the details of your condition (including dates, treatment and duration information) in the space provided on Page 2 (reverse). Failure to do so will cause a delay in the application process.

1. In the past 10 years, have you:  
 Yes  No a. Had transplant surgery?  
 Yes  No b. Been treated for alcoholism or told to change drinking habits by a physician?  
 Yes  No c. Used heroin or other narcotics, marijuana, cocaine, LSD or amphetamines, unless prescribed by a physician?

2. In the past 5 years, have you been diagnosed or treated by a doctor for any conditions listed below?  
 Yes  No a. Dizzy spells, epilepsy, nervous or neurological disorder, migraines or mental disorder  
 Yes  No b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, COPD or lung disorder  
 Yes  No c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack  
 Yes  No d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs  
 Yes  No e. Arthritis, gout, rheumatism, back disorder, disc disease, or joint or bone disorder  
 Yes  No f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus  
 Yes  No g. Sugar in urine, diabetes, kidney or bladder disorder  
 Yes  No h. Anemia, blood vessel disease, bleeding or any other blood disease or disorder  
 Yes  No i. Difficulty with eyes or ears  
 Yes  No j. Chronic fatigue or fibromyalgia

3. a. Are you currently pregnant?  Yes  No If yes, how many months? \_\_\_\_\_  
 b. Have you ever had any complications of pregnancy?  Yes  No

4. In the past 5 year:  
 Yes  No a. \_\_\_\_\_  
 Yes  No b. \_\_\_\_\_  
 Yes  No c. \_\_\_\_\_

5. Do you engage or scuba diving, vehi If yes, indicate on \_\_\_\_\_

6. In the past 5 year:  
 Yes  No a. \_\_\_\_\_  
 Yes  No b. \_\_\_\_\_

You must sign and date Page 1 of 3

## Employee Information:

- Please print clearly.
- Complete in full.

## Employee/Dependent Application:

- Provide full name, date of birth and current height and weight of the person applying for coverage.
- Check box to indicate whether applicant is the employee, spouse or child.

## Sun Life Assurance Company of Canada

### Evidence of Insurability

**Statement of Health - Detail:** If you answer "yes" to any of the questions on Page 1 (reverse), please provide details in the spaces provided below. If you need additional space, check here  and attach a separate sheet.

Question Number	Description/History of Condition	Date (mm/dd/yy)	Duration	Treatment
1	Example: High blood pressure; most recent BP reading; etc.			

**Fraud Warning:** Please read the fraud warning below before signing the Evidence of Insurability form. State law requires that we notify you of the following: (*Residents of Colorado, Louisiana, New Jersey, Oregon, Virginia and Washington please see Page 3.*)

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.

**Declaration:** I declare that to the best of my knowledge and belief the answers on Page 1 and 2 of this form, and those on the attached sheet, are complete and true.

I understand that: (a) I may be refused insurance if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. If Sun Life Assurance Company of Canada declines my coverage, Sun Life Assurance Company of Canada will explain the decision and any medical reason for its refusal. (b) If I ask Sun Life Assurance Company of Canada in writing I can: (i) Get information from my Sun Life Assurance Company of Canada file (a fee may be charged). (ii) Ask Sun Life Assurance Company of Canada to correct, amend or delete information in my file. (iii) File my own statement of facts if I believe any information is incorrect. (iv) Receive a copy of this Authorization. (c) I certify that I have read or had read to me the completed Evidence of Insurability including the Authorization and applicable fraud warning. I realize that any false statement or misrepresentation in it may result in loss of coverage under the Policy. (d) This application is valid for 90 days. (e) If I have any questions, I can write to Sun Life Assurance Company of Canada, Group Life Dept., SC 3227, One Sun Life Executive Park, Wellesley Hills, MA 02481.

**Authorization:** I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, any insurance company or the Medical Information Bureau to release to Sun Life Assurance Company of Canada, any information requested as to diagnosis, treatment, or prognosis with respect to my mental or physical condition, or the mental or physical condition of my dependent named in this application. I understand that information obtained by use of this authorization will be used by Sun Life Assurance Company of Canada to determine if I or my dependents are insurable under the group insurance policy issued by my employer. Sun Life Assurance Company of Canada will not disclose this information to anyone EXCEPT as may be required by law or as I may further allow by express written authorization. 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 this authorization shall be valid for 24 months from the date shown below, and that I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. I am or my authorized representative is entitled to receive a copy of this authorization upon request. A copy of this authorization shall be as valid as the original.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Only if listed on Page 1 as applying for coverage)

**Mail this form to:** Sun Life Assurance Company of Canada  
 Group Life Department, SC 3227  
 One Sun Life Executive Park  
 P.O. Box 81100  
 Wellesley Hills, MA 02481

**Or, fax application to:** (781) 446-1517

## Statement of Health Detail:

- If you answered "yes" to any questions within the "Statement of Health," please provide full details here.

## Signature:

- Please read the fraud warning, declaration and authorization. Then, sign and date the form.

# Sun Life Assurance Company of Canada

## Evidence of Insurability Application



**Employee:** Please be sure your employer has completed the shaded box below left. Then, complete all sections below. Complete a separate form for your spouse and/or children only if they are applying for coverage. Read and sign this form on Page 2 (reverse) before submitting it to us. Mail completed form to Sun Life Financial, Group Medical Underwriting, SC 7190, 15 Rye Street, Portsmouth, NH 03801. Questions about this form? Call 1-800-247-6875. **Please print clearly.**

**Employer Use Only:** Please complete the section below before providing this form to the employee:

**Group Policy Number:**

**Approval Requested For:**  
 Employee  
 Dependent(s)

**Total Amount Requested:**  
**Life Insurance**  
 Employee Basic \$  
 Employee Opt'l \$  
 Spouse Opt'l \$  
 Child Optional \$

**Other Coverages**  
 LTD  STD  Other: \_\_\_\_\_  
 Amount Requested \$

**Type of Application:**  
 New Hire (over Guaranteed Issue amount)  
 Late Applicant (previously waived)  
 Qualifying Event (marriage, birth of child, etc.)  
 Please indicate date of event:  
  
 Increase coverage. Please indicate prior amount of coverage in-force:  
 Employee ..... \$   
 Spouse/Child .. \$

**Employer Signature:**

**Date:**

Please complete all applicable sections on Page 2 (reverse). If you answer "yes" to any of the questions at right, please provide details in the space provided on Page 2.

Employee Name (first, middle initial, last)			
Residence Address (street no. and name, apt. or suite)		Employer Name	
City	State	Zip	Employee's Home Phone No.
Social Security Number		Date of Employment	Occupation
			Annual Salary

**Person Applying for Coverage:**  Employee  Spouse  Child  Male  Female

Name (first, middle initial, last)	Date of Birth	Height	Weight
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**Statement of Health:** If you answer "yes" to any of the questions, please write in the details of your condition (including dates, treatment and duration information) in the space provided on Page 2 (reverse). Failure to do so will cause a delay in the application process.

- In the past 10 years, have you:
  - Yes  No a. Had transplant surgery?
  - Yes  No b. Been treated for alcoholism or told to change drinking habits by a physician?
  - Yes  No c. Used heroin or other narcotics, marijuana, cocaine, LSD or amphetamines, unless prescribed by a physician?
- In the past 5 years, have you been diagnosed or treated by a doctor for any conditions listed below?
  - Yes  No a. Dizzy spells, epilepsy, nervous or neurological disorder, migraines or mental disorder
  - Yes  No b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, COPD or lung disorder
  - Yes  No c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack
  - Yes  No d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs
  - Yes  No e. Arthritis, gout, rheumatism, back disorder, disc disease, or joint or bone disorder
  - Yes  No f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus
  - Yes  No g. Sugar in urine, diabetes, kidney or bladder disorder
  - Yes  No h. Anemia, blood vessel disease, bleeding or any other blood disease or disorder
  - Yes  No i. Difficulty with eyes or ears
  - Yes  No j. Chronic fatigue or fibromyalgia
- a. Are you currently pregnant?  Yes  No If yes, how many months? \_\_\_\_\_
  - b. Have you ever had any complications of pregnancy?  Yes  No
- In the past 5 years, have you:
  - Yes  No a. Had surgery, injuries or been treated in a hospital?
  - Yes  No b. Been off work for more than 5 consecutive days due to illness or injury?
  - Yes  No c. Lost 10 lbs. or more over a 12 month period? If yes, give amount: \_\_\_\_\_ lbs.
- Do you engage or expect to engage in any of the following activities: skydiving, scuba diving, vehicle or boat racing or aviation except as a passenger?  Yes  No  
 If yes, indicate on Page 2 (reverse) which activity, how often and last time participated.
- In the past 5 years, have you:
  - Yes  No a. Been refused life or health insurance, or offered it on special terms?
  - Yes  No b. Been diagnosed as having, or been treated by a member of the medical profession for HIV/Acquired Immune Deficiency Syndrome (AIDS)?

# Sun Life Assurance Company of Canada

## Evidence of Insurability

**Statement of Health - Detail:** If you answer "yes" to any of the questions on Page 1 (reverse), please provide details in the spaces provided below. If you need additional space, check here  and attach a separate sheet.

Question Number	Description/History of Condition Example: High blood pressure; most recent BP reading; etc.	Date (mm/dd/yy)	Duration	Treatment

**Fraud Warning:** Please read the fraud warning below before signing the Evidence of Insurability form. 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 subjects such person to criminal and civil penalties.

**Declaration:** I declare that to the best of my knowledge and belief the answers on Page 1 and 2 of this form, and those on the attached sheet, are complete and true.

I understand that: (a) I may be refused insurance if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. If Sun Life Assurance Company of Canada declines my coverage, Sun Life Assurance Company of Canada will explain the decision and any medical reason for its refusal. (b) If I ask Sun Life Assurance Company of Canada in writing I can: (i) Get information from my Sun Life Assurance Company of Canada file (a fee may be charged). (ii) Ask Sun Life Assurance Company of Canada to correct, amend or delete information in my file. (iii) File my own statement of facts if I believe any information is incorrect. (iv) Receive a copy of this Authorization. (c) I certify that I have read or had read to me the completed Evidence of Insurability including the Authorization and applicable fraud warning. I realize that any false statement or misrepresentation in it may result in loss of coverage under the Policy. (d) This application is valid for 90 days. (e) If I have any questions, I can write to Sun Life Financial, Group Medical Underwriting, SC 7190, 15 Rye Street, Portsmouth, NH 03801.

**Authorization:** I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, any insurance company or the Medical Information Bureau to release to Sun Life Assurance Company of Canada, any information requested as to diagnosis, treatment, or prognosis with respect to my mental or physical condition, or the mental or physical condition of my dependent named in this application. I understand that information obtained by use of this authorization will be used by Sun Life Assurance Company of Canada to determine if I or my dependents are insurable under the group insurance policy issued to my employer. Sun Life Assurance Company of Canada will not disclose this information to anyone EXCEPT as may be required by law or as I may further allow by express written authorization. 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 this authorization shall be valid for 24 months from the date shown below, and that I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. I am or my authorized representative is entitled to receive a copy of this authorization upon request. A copy of this authorization shall be as valid as the original.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_  
(Only if listed on Page 1 as applying for coverage)

**Mail this form to:** Sun Life Financial  
Group Medical Underwriting, SC 7190  
15 Rye Street  
Portsmouth, NH 03801

**Or, fax application to:** (781) 446-1517

# Sun Life Assurance Company of Canada

## Authorization



### 1. Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all Authorizations. Incomplete information could delay your application..

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; or the Medical Information Bureau, Inc., to disclose my entire medical record and any other protected health information concerning me to 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 and 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 entity named above 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.

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 the Group Compliance Department, Sun Life Financial, SC 2260, 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 Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

## 2. Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all Authorizations.

Incomplete information could delay your application.

I **HEREBY AUTHORIZE** any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, therapist or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) insurance company; and (c) insurance support organization to disclose any psychotherapy notes relating to me to 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 entity named above 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) 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 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 the Group Compliance Department, Sun Life Financial, SC 2260, 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 Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)