Sun Life Insurance and Annuity Company of New York

Application for Long Term Disability Conversion Insurance

Customer Service Center:
Group LTD Conversion, SC 1219
One Sun Life Executive Park
Wellesley Hills, MA 02481
1-800-247-6875

Your name (first, middle initial, last) ☐ Male ☐ Female	Social Security Number	Date of birth (m/d/y)
Address (number and street, city, state, zip)		Telephone number ( )
Name of your employer	Group policy number	Telephone number ( )
Date of termination of employment (m/d/y)	Date of termination of Long Term Disability coverage under your employer's plan	
Basic monthly salary as of date of termination (not including commissions, bonuses, or overtime) $	Gross monthly benefit you are applying for $	

Premium

The amount of premium due on a quarterly basis will be as shown on the conversion insurance Policy. The amount paid with this Application is $_____ together with a one-time administration fee of $_____. I agree to pay the balance, if any, of the quarterly premium due as calculated by Sun Life over the amount paid with this Application. Sun Life Insurance and Annuity Company of New York will refund to me any amount that is in excess of the required premiums for the Conversion Insurance.

Eligibility

You must have been insured by Sun Life and the prior carrier (if any) under your employer's Long Term Disability plan for at least twelve consecutive months at the time your Group Long Term Disability insurance under your employer's plan terminated.

Effective Date

If this Application is approved by Sun Life (N.Y.), your insurance will be effective at 12:01 AM on the day after your coverage under your employer's Group Long Term Disability insurance terminates.

Contract

Your insurance contract will consist of this Application and the insurance policy together with any riders of amendments issued by Sun Life (N.Y.).

Fraud Warning

To the best of my knowledge and belief, all the foregoing statements of this Application are true, complete and correctly stated. They are offered to Sun Life (N.Y.) as the basis for any insurance issued on this Application. I understand that any false statements may result in the loss of coverage under the policy.

Fraud Warning -- For Residents of 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.

Statements in this Application are representations and not warranties.

To the best of my knowledge and belief, all the foregoing statements of this Application are true, complete and correctly stated. They are offered to Sun Life (N.Y.) as the basis for any insurance issued on this Application. I received an Outline of Coverage with this Application.

Fraud Warning -- For Residents of Pennsylvania

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.

Applicant's Signature_____ Date_____