Sun Life and Health Insurance Company (U.S.)

Long Term Disability Claim Packet - Claimant

Instructions for the Claimant

Please mail all documents 4-6 weeks before the end of your elimination period.

Please make sure to initiate the Long Term Disability claim filing process as soon as it first appears that your disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

It is the responsibility of the claimant to ensure that the Employer's Statement and the Attending Physician's Statement are submitted directly to Sun Life Financial.

Please be sure to submit the Employee's Statement directly to Sun Life Financial.

The Employee must:

- ☐ Sign and date the Employee's Statement
- ☐ Sign and date the Authorizations
- ☐ Sign and date the Reimbursement Agreement
- ☐ Have the employer complete and return the Employer's Statement to Sun Life Financial
- ☐ Have the physician complete and return the Attending Physician's Statement to Sun Life Financial
- ☐ Attach a copy of a photo ID (i.e., license or passport)
- ☐ Attach a detailed job description (from employer)

Mail or fax the completed claim form to:

Sun Life and Health Insurance Company (U.S.)
Group Long Term Disability Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095
Fax: (781) 304-5425

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

Fraud Warnings

State law requires that we notify you of the following:

Fraud warning: 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.

Fraud warning—AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Fraud warning—AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Fraud warning—AR, LA, MA, MN, NM, RI, TX, and WV: 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.

Fraud warning—AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Fraud warning—CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud warning—CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud warning—DC: 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.

Fraud warning—DE, ID, and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—FL: 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.

Fraud warning—KS: 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 may be guilty of insurance fraud as determined by a court of law.

Fraud warning—KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Fraud warning—MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud warning—ME, TN, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Fraud warning—NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Fraud warning—NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud warning—OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud warning—OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud warning—OR and VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud warning—PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Fraud warning—VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Continued on next page

Sun Life and Health Insurance Company (U.S.)

Long Term Disability Claim Packet - Claimant

Sun Life Financial®

Employee's Statement

1 General Information

Please print clearly.

Return to:
Sun Life and Health
Insurance Company (U.S.)
Group LTD Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095
Fax: (781) 304-5425

Name of employee (first, middle initial, last) ☐ M ☐ F	Social Security number	Group policy number 923463
Street address	City	State / Zip Code
Occupation	Date of birth	Phone number / Marital status
Spouse's name (first, middle initial, last)	Social Security number	Date of birth

Is your spouse employed ..... ☐ Yes ☐ No
Names and dates of birth of your children (under age 25)

2 Information About the Condition Causing Your Disability

If a motor vehicle accident has occurred and is the cause of the disability, a motor vehicle accident report is required to be included with this statement.

Date of accident or date you first noticed symptoms of your illness _____		
Describe in detail how, when and where the accident occurred –OR – Describe the nature of your illness/condition and its first symptoms.		
Is your condition due to injury or sickness related to your job?..... ☐ Yes ☐ No If yes, please explain below.		
Date you were first treated by a physician	Last date worked prior to disability	Did you work a full day? ☐ Yes ☐ No
Date first unable to work	Have you returned to work? ☐ Yes ☐ No If yes, Date: ☐ With restrictions ☐ Full capacity	
If work-related, have you filed/do you intend to file, a Workers' Compensation claim? ☐ Yes ☐ No If yes, provide date:		

3 Your Treating Physician(s)

If you need more space, check here ☐ and attach a separate page.

Name of physician	Specialty
Address	
Telephone number / Fax number / Date of last visit / Date of next visit	
Have you discussed a return to work plan with this physician?..... ☐ Yes ☐ No	

Continued on next page

3 Your Treating Physician(s) continued

Name of physician			Specialty
Address			
Telephone number	Fax number	Date of last visit	Date of next visit
Have you discussed a return to work plan with this physician?..... ☐ Yes ☐ No			

4 Hospitals

If you need more space, check here ☐ and attach a separate page.

1.	Name of hospital	Telephone number	Dates of confinement to
2.	Name of hospital	Telephone number	Dates of confinement to

5 Other Income Information

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

Check all that apply and provide award/denial notice or application associated with any source of income.

	Source of income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐	Sick Pay	$	☐ Wkly ☐ Mthly	
☐	Salary Continuance	$	☐ Wkly ☐ Mthly	
☐	State Disability	$	☐ Wkly ☐ Mthly	
☐	Workers' Compensation	$	☐ Wkly ☐ Mthly	
☐	Unemployment Compensation	$	☐ Wkly ☐ Mthly	
☐	Social Security Disability/Retirement	$	☐ Wkly ☐ Mthly	
☐	Disability/Retirement Pension	$	☐ Wkly ☐ Mthly	
☐	Automobile No-fault Insurance	$	☐ Wkly ☐ Mthly	
☐	Union Disability	$	☐ Wkly ☐ Mthly	
☐	Severance	$	☐ Wkly ☐ Mthly	
☐	Other:	$	☐ Wkly ☐ Mthly	

6 Education and Training Information

Please indicate your highest level of education completed. ☐ Less than High School (Grade: _____) ☐ High School (GED) ☐ College		
Name of school / college		
Degree	Dates attended	Field of study

Additional Course Work, Education, Training, Special Skills and/or Hobbies

7 Experience Information

Military Experience

Did you serve in the armed forces?..... ☐ Yes ☐ No		Branch of service
Highest rank	Dates of service to	Specialty

Continued on next page

7 Experience Information continued

If you have a resume, please attach a copy. You may use this section to indicate any additional experience.

Work Experience

Please list chronologically all of the jobs you have held. Start with your current or most recent job. Provide as many details as possible.

Name of Employer	Title	Dates of employment
City of Milwaukee		to
Department	**Tasks and duties (please be specific)**	
HACM		

Name of Employer	Title	Dates of employment
		to
Department	**Tasks and duties (please be specific)**	

Name of Employer	Title	Dates of employment
		to
Department	**Tasks and duties (please be specific)**	

Skills Development

What, if any, training or education would you be interested in pursuing?

8 Checklist of Required Attachments

Please mail all documents 4-6 weeks before the end of your elimination period. **Failure to provide the following information could result in a delay of the initial benefit payment.**

- ☐ Sign and date the Employee's Statement
- ☐ Sign and date the Authorizations
- ☐ Sign and date the Reimbursement Agreement
- ☐ Employer completed and returned the Employer's Statement
- ☐ Physician completed and returned the Attending Physician's Statement
- ☐ Attach a copy of a photo ID (i.e., license or passport)

We will contact you as soon as we have received and reviewed your claim forms and medical records. In the meantime, should you have any questions, please call our Customer Service Center at 1-800-247-6875.

9 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 or had read to me the fraud warning for my state.

Employee's signature	Date signed
X	

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Sun Life and Health Insurance Company (U.S.)

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 and Health Insurance Company (U.S.)
Group LTD Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095

Fax: (781) 304-5425

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager 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 and Health Insurance Company (U.S.) ("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 healthcare provider 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.

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, 175 Addison Road, P.O. Box 725, Windsor, CT 06095, 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 923463
If Representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Sun Life and Health Insurance Company (U.S.)

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 and Health Insurance Company (U.S.)
Group LTD Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095

Fax: (781) 304-5425

I HEREBY AUTHORIZE any: physician, healthcare provider, health plan, medical professional, hospital, clinic, or other medical or healthcare 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 and Health Insurance Company (U.S.) ("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 healthcare 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) 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.

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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, 175 Addison Road, P.O. Box 725, Windsor, CT 06095, 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 923463
If Representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Sun Life and Health Insurance Company (U.S.)

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 and Health Insurance Company (U.S.)
Group LTD Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095

Fax: (781) 304-5425

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager or other medical or healthcare 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 and Health Insurance Company (U.S.) ("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 no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Group Long Term Disability Claims, Sun Life Financial, 175 Addison Road, P.O. Box 725, Windsor, CT 06095, 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 923463
If Representative, description of your authority or relationship to employee	
Signature of employee or personal representative X	Date

Reimbursement Agreement

Return to:
Sun Life and Health
Insurance Company (U.S.)
Group LTD Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095

Fax: (781) 304-5425

I UNDERSTAND and agree that the provisions of Group Long Term Disability Policy No. 923463 permit Sun Life and Health Insurance Company (U.S.) (herein called the "Company") to offset from my monthly disability benefit any benefits received from Social Security and/or Workers' Compensation or as otherwise provided in the Group Long Term Disability Policy. I further UNDERSTAND and agree that the Company may offset any such amounts that I or my dependents are eligible to receive, whether or not I or my dependents are actually receiving said amounts.

In return for the Company's advance payment of the Long Term Disability benefits to which I may be entitled, which advanced amount may be in excess of the amount due to me under the terms of the policy, I, for myself, my heirs, executors, administrators and assigns agree:

1. That I am not currently receiving any benefits from Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy.
2. To apply for Social Security disability benefits and/or Workers' Compensation benefits, and/or any Other Income benefit to which I or my dependents may be eligible as described in the policy.
3. If I, and/or my spouse and family receive any disability payments, regardless of the amount, in connection with Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I or my spouse and family may be eligible as described in the policy; I and/or my spouse and family will immediately notify the Company of such disability payments and will pay back all amounts over and above the amounts to which I would be entitled under the policy provisions.
4. I understand that thereafter the Company is entitled to offset any amounts received from Social Security and/or Workers' Compensation, and/or any Other Income benefit to which I may be eligible as described in the policy with the monthly benefit payable under the policy in accordance with the terms of the policy.

I UNDERSTAND that the Company, in reliance on the above statements and promises, has agreed to advance to me the disability benefits to which I or my dependents are entitled under the terms of the policy.

Print name	Group policy number 923463
Signature of employee X	Date
Signature of witness X	Date

Sun Life Assurance and Health Insurance Company (U.S.)
Wellesley Hills, MA 02481
1-800-247-6875

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life and Health Insurance Company (U.S.) ("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 or to evaluate your claim. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, healthcare 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 and Health Insurance Company (U.S.)
Group Long Term Disability Claims
175 Addison Road
P.O. Box 725
Windsor, CT 06095