For your protection, the following disclosures are required by state law and are based on the state where you live:

**If you live in New York the following statement applies to you:**
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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**If you live in the state of Alaska, the following statement applies to you:**
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.

**If you live in the state of Alabama, the following statement applies to you:**
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.

**If you live in the states of Arkansas, Louisiana, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas or West Virginia, the following statement applies to you:**
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.

**If you live in the state of Arizona, the following statement applies to you:**
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.

**If you live in the state of California, the following statement applies to you:**
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.

**If you live in the state of Colorado, the following statement applies to you:**
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.
If you live in the District of Columbia, the following statement applies to you:
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.

If you live in the states of Delaware, Idaho or Indiana, the following statement applies to you:
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.

If you live in the state of Florida, the following statement applies to you:
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 of the third degree.

If you live in the state of Kansas, the following statement applies to you:
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.

If you live in the state of Kentucky, the following statement applies to you:
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.

If you live in the state of Maryland, the following statement applies to you:
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.

If you live in the state of Maine, the following statement applies to you:
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.

If you live in the state of New Hampshire, the following statement applies to you:
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.

If you live in the state of New Jersey, the following statement applies to you:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

If you live in the state of Ohio, the following statement applies to you:
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.

If you live in the state of Oklahoma, the following statement applies to you:
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.

If you live in the states of Oregon or Virginia, the following statement applies to you:
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.

If you live in the states of Tennessee or Washington, the following statement applies to you:
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.

If you live in the state of Vermont, the following statement applies to you:
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.

If you live in a state other than mentioned above, the following statement applies to you:
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.
Please read the following instructions carefully for proper completion of the attached Life Insurance Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion. If you also have Long Term Disability Insurance with Sun Life Financial, completion of this form may not be necessary. Please contact the Life Benefit Center for information.

Do not separate the pages of this Claim Statement. Additional physician’s statements may be obtained from the Life Benefit Center, or by copying the physician’s statement included in this statement. Attach any additional physician’s statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. After the Employer and Claimant Statements are fully completed, forward the entire statement to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

Instructions for completion of the Employer’s sections follow:

**Employer Claim Statement—Part 1**

Please indicate at the top of the form whether or not this is a new claim.

1.–7. Self-explanatory.
8. Effective date of the claimant’s Life coverage.
9. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.
10. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.
11. Provide the reason the claimant ceased working.
14. Any other coverages the claimant has with Sun Life Financial. (i.e., Disability, Medical, Dental, etc.)
15. A–D If the claimant has returned to work, advise us of his/her current work schedule.
   Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.
16.–19. The claimant’s basic annual earnings as of the determination date indicated in your Life policy. For #16, if the claimant receives any bonuses, commissions, or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.
24. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

**Employer Claim Statement—Part 2**

Fully complete this section of the claim statement for all claims.

Please attach a copy of the employer’s own description of the claimant’s position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant’s position. This section should be completed by someone who is familiar with the claimant’s position; i.e. supervisor.

**Physical Aspects**

1. Self-explanatory.
2. Please tell us how often the claimant does each of the activities listed, and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.
   Never = 0 hours; Occasionally = 1/2–2-1/2 hours; Frequently = 2-1/2–5-1/2 hours;
   Continuously = 5-1/2 hours or more
3.–5. Self-explanatory.

**Stress/Non Physical Aspects**

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.
<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of employer</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Group Policy no.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Group Participation no.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Account no.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Full name of claimant</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Social Security no.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Date employed</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Effective date</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Date last worked</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Number of hours worked that day</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Reason for not working after this date</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Work schedule of claimant at time of disability:</td>
<td>days per week  hours per day</td>
</tr>
<tr>
<td>13</td>
<td>Was claimant a member of a union at the time of disability?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>14</td>
<td>Does claimant have any other coverage(s) with Sun Life Financial?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>15</td>
<td>Is the insured engaged in any gainful employment, even in a limited way?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>16</td>
<td>Basic annual salary (as defined in Policy)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>How is claimant paid?</td>
<td>Hourly  Salary + Commission  Salaried  Commission only  Salary + Bonus  Other</td>
</tr>
<tr>
<td>18</td>
<td>Date of last increase in the amount of life insurance</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Amount of life insurance as of date last worked</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Has the employment of the insured been terminated solely because of disability?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>21</td>
<td>If your group plan is on a self-administered basis, please indicate:</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Remarks</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Authorized Signature/Title</td>
<td></td>
</tr>
</tbody>
</table>

**Information**

- **Employer Claim Statement—Part 1**
- **Disability Claim Statement—Life Insurance**
- **New claim:** Yes  No
- **Reason for not working after this date:**
- **Reason for not working after this date:**
- **Work schedule of claimant at time of disability:** days per week hours per day
- **Was plan effective when disability began?** Yes  No
- **If “No,” please indicate date of termination:**
- **Was claimant a member of a union at the time of disability?** Yes  No
- **Does claimant have any other coverage(s) with Sun Life Financial?** Yes  No | If “Yes,” please advise of the type of coverage(s). |
- **Is the insured engaged in any gainful employment, even in a limited way?** Yes  No
- **How is claimant paid?**
- **Basic annual salary (as defined in Policy):**
- **Date of last increase in the amount of life insurance:**
- **Amount of life insurance as of date last worked:**
- **Has the employment of the insured been terminated solely because of disability?** Yes  No
- **If your group plan is on a self-administered basis, please indicate:**
- **To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?**
- **Remarks:**
- **Date:**
- **Authorized Signature/Title:**
- **Fax no.**
- **Phone no.**
Employer Claim Statement—Part 2  
Physical/Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant’s job.

Claimant’s occupation __________________________________________________________

Signature/Title ___________________________________________ Date __________________

---

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Total No. of Hours</th>
<th>At Will</th>
<th>May Alternate Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Claimant must

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Continuously</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bend/Stoop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Climb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Reach above shoulder level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Kneel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Enter data/keystroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Squat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Crawl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Crouch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Lift: Usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Carry Usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Push/Pull Usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.  
   Right: [ ] Yes  [ ] No  Left:  [ ] Yes  [ ] No  Both:  [ ] Yes  [ ] No

4. On the job, claimant uses hands for repetitive action such as:

   Simple Grasping  Firm Grasping  Fine Manipulation
   A. Right        [ ]             [ ]             [ ]
   B. Left         [ ]             [ ]             [ ]

5. Does job require:
   A. Working at unguarded heights?  [ ] Yes  [ ] No
   B. Exposure to marked changes in temperature and humidity or extremes thereof?  [ ] Yes  [ ] No
   C. Exposure to dust, fumes, gases, chemicals?  [ ] Yes  [ ] No

---

Stress/Non Physical

1. Percentage of time claimant spends answering customer complaints. _____%
2. Percentage of claimant’s work primarily judged on production. _____%
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?  
   [ ] Yes  [ ] No  _____% of time
4. How many employees does this claimant supervise?  
5. Is this claimant routinely subject to close supervision?  [ ] Yes  [ ] No
6. Percentage of time spent by the claimant working with his/her co-workers. _____%
7. Percentage of claimant’s time spent on:  
   Prescheduled activities: _____%  
   Random activities: _____%
8. Percentage of time claimant spends meeting deadlines set by others. _____%
9. Percentage of responsibility the claimant has for the performance of his/her particular department. _____%
Claimant Statement—Part 1 (Please print or type.)

Section I

1. Full name
2. Social Security no.
3. Date of birth
4. Address (street, city, state, zip code)
5. Home phone no.
6. Sex: □ Male □ Female
7. Marital Status: □ Single □ Married □ Separated □ Widowed □ Divorced
8. Your occupation

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred.
2. Date first unable to work because of this disability.
3. Have you returned to work? □ Yes □ No
   If “Yes,” on what date: _______ Part-time _______ Full-time
   If you have not returned to work, on what date do you expect to return to work? _______ Part-time _______ Full-time

4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.

   Name
   Address
   Dates of consultation
   First Visit
   Last Visit

5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.

   Name of Hospital
   Address
   From
   To

Section III

1. A. Has your condition prevented you from doing any job for which your education, training or experience qualifies you?
   □ Yes □ No

2. B. If “Yes,” since what date has disability been total and continuous?

3. C. Are you receiving or have you applied for Social Security Disability Benefits? □ Yes □ No □ Ineligible
   If ineligible, explain.

   (Please forward a copy of Award or Denial letter from Social Security as soon as it is available.)

Section IV

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Life Insurance Company of New York, or its representatives, any and all such information. I UNDERSTAND the information obtained by use of this authorization will be used by Union Security Life Insurance Company of New York to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Signature of claimant _____________________________ Date ___________________________
Claimant Statement—Part 2 (Do not complete this section if you have returned to work, or if disability is for pregnancy.)

Training, Education & Experience

1. What is your level of education?
   A. Have you received a high school diploma or the equivalent of a high school diploma? □ Yes □ No
      If “No,” please advise us of the last grade completed. _______________ grade
   B. Have you attended college? □ Yes □ No
      □ Some college □ College graduate □ Post graduate
      Please specify: Major field of study __________________________
      Degree earned __________________________
      Date last attended __________________________
   C. Have you attended any trade schools or received any other special training? □ Yes □ No
      Please specify: Type of training __________________________
      Date last attended __________________________

2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.

3. What was your occupation when disability commenced and what were the usual duties of your occupation?

4. Which of the above job duties are you unable to perform?

5. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor? □ Yes □ No

6. Have you asked your employer to provide any accommodations which would allow you to return to work? □ Yes □ No  If “Yes,” what accommodations did you request and what was your employer’s response?

7. What accommodations do you feel could be made by your employer to allow you to return to work?

8. Have you considered retraining? □ Yes □ No  If “Yes,” what vocational area(s) would interest you?

9. Please list any hobbies, outside interests or activities.

10. If you are receiving Workers’ Compensation benefits, have you been contacted by the Workers’ Compensation carrier regarding vocational rehabilitation? □ Yes □ No
      If “Yes,” what is the name, address and phone number of the counselor handling your case?

11. Have you contacted your state Division of Vocational Rehabilitation Department? □ Yes □ No
      If “Yes,” what is the name, address and phone number of the counselor handling your case?
**Attending Physician’s Initial Statement of Disability**

The patient must pay any costs for completion of this form.

**To the Attending Physician**

Please read the following instructions before completing this form.

**Do not separate the pages of this claim statement.** An authorization to release information can be found in Part 1 of the Claimant’s Statement.

Clearly print or type this form. Complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the reverse side of this form. The Job Description is Part 2 of the Employer’s Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant’s Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Date of birth</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**History**

Patient’s symptoms result from (Check all that apply):  
- Employment
- Illness

Auto accident (state in which accident occurred)  

Pregnancy (expected/actual delivery date)  

Date symptoms first appeared  

Patient’s height  

Weight  

First visit for this condition  

Most recent visit  

Most recent comprehensive exam  

Frequency:  
- Weekly
- Monthly
- Other (Specify)  

Name(s) and address(es) of other treating or referring physician(s)  

Hospital name  

Confinement dates  

**Diagnoses**

Diagnoses (including any complications)  

Subjective symptoms  

Objective findings (Include results/copies of x-rays, lab tests, EKGs, MRIs and scans)  

Attach medical records as appropriate.

**Treatment**

Describe treatment program, including dates of any surgery, medications, physical therapy or psychotherapy.

**Psychiatric Impairment**

Complete only if applicable.

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

Remarks  

What stress and problems in interpersonal relations has patient had on the job?

Do you believe a legal guardian or conservator should be appointed for this patient?  
- Yes
- No
<table>
<thead>
<tr>
<th>Physical Impairment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently......................................................... No restrictions (0–10%)</td>
<td></td>
</tr>
<tr>
<td>Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently............................................................................. (15–30%)</td>
<td></td>
</tr>
<tr>
<td>Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently .................................................. (35–55%)</td>
<td></td>
</tr>
<tr>
<td>Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# of force, mostly sitting ........................................................................................................ (60–70%)</td>
<td></td>
</tr>
<tr>
<td>Class 5—Severe limitation; incapable of minimal activity or sedentary* work ........................................................................................................... (75–100%)</td>
<td></td>
</tr>
</tbody>
</table>

*As defined in the Federal Dictionary of Occupational Titles

<table>
<thead>
<tr>
<th>Cardiac</th>
<th>Functional capacity (American Heart Association) Complete only if applicable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1 (no limitation)</td>
<td>Class 2 (slight limitation)</td>
</tr>
</tbody>
</table>

Blood pressure (latest reading) ___________________________ as of (date) ____________

Is patient in a cardiac rehabilitation program? □ Yes □ No

**DOCTOR:** Check if you have reviewed the:
- □ Job Description
- □ Training, Education & Experience

Please describe fully how patient’s symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why?

When did these limitations apply? Began ____________ Ended ____________

When would you anticipate a reduction of these symptoms? ____________

<table>
<thead>
<tr>
<th>Prognosis</th>
<th>Prognosis: □ Terminal □ Poor □ Good □ Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Would any further therapy be reasonably expected to result in full or partial recovery?</td>
</tr>
<tr>
<td>□ Yes (Describe below.)</td>
<td>When ____________ □ No □ Unknown</td>
</tr>
</tbody>
</table>

Has patient reached maximum medical improvement? □ Yes □ No If “No,” when ____________ □ Unknown

<table>
<thead>
<tr>
<th>Rehab</th>
<th>Is patient a candidate for rehabilitation services? □ Yes (Describe.) □ No (Explain.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Would job modification enable patient to work with impairment? □ Yes (Describe.) □ No</td>
</tr>
<tr>
<td></td>
<td>Would vocational counseling and/or retraining be recommended? □ Yes (Elaborate.) □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Physician’s name ____________________________________________________________________ Degree/Specialty ____________________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address ______________________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>Telephone no. _________________________________________________________________________ Fax no. _________________________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>Signature ___________________________________________________________________________ Date ____________________________</td>
</tr>
</tbody>
</table>

DO NOT DETACH
HIPAA Authorization for Release of Protected Health Information—Life

Insured/Member name ____________________________ SS no. ____________
Address ____________________________ City ____________ State ____________ Zip code ____________

Individual who is the Subject of Protected Health Information ____________________________
Policy no. ____________ Participation no. ____________ Account no. ____________ Certificate no. ____________

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.


I hereby authorize the use or disclosure of protected health information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employment-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

• I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies’ insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.

• This authorization is voluntary. I may revoke it at any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that the Companies took before receipt of the revocation.

• Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.

• I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.

• The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

__________________________  ____________________________
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE  DATE

Printed name of personal representative ____________________________

Relationship to insured/member ____________________________
(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records.

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

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