Sun Life Financial

Evidence of Insurability Application – Health Questionnaire

☐ Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

☐ Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

- You are applying for coverage from one of the insurance companies above, outside of New York, which is referred to as "The Company" on this application. Please refer to your Plan Administrator for the correct underwriting company.
- Complete and return the entire application and the instructions page to Sun Life Financial.

1 Employee information (Please print clearly)

Employer name	Group policy number	Division/location	Billing code

Employee name (first, middle initial, last)			

Employee street address	City	State	Zip code

Social Security number – –	Daytime phone number	Evening phone number

E-mail address	Occupation

2 Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by The Company. No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

	First name	Last name	DOB (mm/dd/yyyy)	Height	Weight	Gender
Employee						☐ M ☐ F
Spouse/ partner						☐ M ☐ F
Child 1						☐ M ☐ F
Child 2						☐ M ☐ F
Child 3						☐ M ☐ F

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
1. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
2. Stroke, transient ischemic attack (TIA), high blood pressure, irregular heart beat, heart murmur, aneurysm, heart attack, angina, elevated cholesterol, or any blood, heart, or blood vessel disorder?	☐	☐	☐	☐	☐	☐
3. Cancer, leukemia, tumor, neoplasm, nodule or polyp (excluding nasal polyp), pre-cancerous condition, or dysplastic nevi?	☐	☐	☐	☐	☐	☐
4. Diabetes, hepatitis, or other disorder of the liver or pancreas; thyroid, pituitary or other endocrine disorder; ulcer, colitis or Crohn's disease, diverticulitis, or other gastrointestinal disorder?	☐	☐	☐	☐	☐	☐
5. Disorder of the kidney, bladder (excluding healed bladder infections or urinary `system, or reproductive organs?	☐	☐	☐	☐	☐	☐

2 Health and personal history, continued

(Complete the following for all persons applying for coverage requiring underwriting)

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
6. Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, cystic fibrosis or any lung or respiratory disorder?	☐	☐	☐	☐	☐	☐
7. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus; connective tissue disease; or fibromyalgia?	☐	☐	☐	☐	☐	☐
8. Headaches, epilepsy, seizures, paralysis, memory loss, intellectual disability, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), multiple sclerosis, muscular dystrophy, or any brain or neurological disorder, chronic infection, or chronic fatigue?	☐	☐	☐	☐	☐	☐

In the last ten years have you or any of your dependents ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
9. Skin disorder that lasted for more than 6 months?	☐	☐	☐	☐	☐	☐
10. Anxiety, depression or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder; or schizophrenia?	☐	☐	☐	☐	☐	☐
11. Disorder of the eyes or ears (excluding healed ear infections)?	☐	☐	☐	☐	☐	☐
12. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	☐	☐	☐	☐	☐	☐

In the last ten years have you or any of your dependents:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?	☐	☐	☐	☐	☐	☐
14. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional?	☐	☐	☐	☐	☐	☐
15. Been off work for more than five consecutive days due to an illness or injury?	☐	☐	☐	☐	☐	☐
16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been arrested in connection will alcohol or drugs; or received treatment in connection with alcohol or drugs?	☐	☐	☐	☐	☐	☐
17. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended?	☐	☐	☐	☐	☐	☐
18. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	☐	☐	☐	☐	☐	☐
19. Are you or one of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐

Have you or any of your dependents:	Employee		Spouse/- partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
20. In the last 2 years, piloted an aircraft, engaged in motor vehicle racing, auto racing, boat racing, hang gliding, parachuting, climbing, scuba diving, or any similar sport or avocation?	☐	☐	☐	☐	☐	☐
21. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	☐	☐	☐	☐	☐	☐
22. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional?	☐	☐	☐	☐	☐	☐

3 **Details** (provide details below for all questions answered "yes.")

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question number	Applicant name	State and provide details for each condition and activity	Date condition began	Duration of condition and treatment	Physician name, address and phone number	Fully recovered?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Please provide physician information even if you answered "no" to all the questions.

Name and address of physician with your most up-to-date and comprehensive medical records:

4 Acknowledgement, authorization for release and disclosure of health related information and signature

Acknowledgement

I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.

If I have any questions regarding my EOI Application, I can write to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481.

4 Acknowledgement, authorization for release and disclosure of health related information and signature, continued

I AUTHORIZE any physician, health care 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 Medical Underwriting Department of Sun Life Assurance Company of Canada or 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 that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that 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 does 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, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to [Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 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.

Signature of employee X	Date signed
Signature of spouse/partner (If application is for spouse/partner) X	Date signed

5 Fraud warnings

General 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.

For AL the following fraud warning applies: 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.

For AR, LA, MA, NM, RI, and WV the following fraud warning applies: 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.

For CO the following warning applies: 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.

For the District of Columbia the following notice applies: 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.

5 Fraud Warnings, continued

For FL the following notice applies: 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.

For KS the following notice applies: 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.

For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, 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.

For MD the following notice applies: 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.

For ME, TN, and WA the following notice applies: 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.

For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For OH the following notice applies: 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.

For OK the following notice applies: 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.

For OR and VA the following notice applies: 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.

For PR the following notice applies: 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.

For VT the following notice applies: 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.

Contact us

By mail
Sun Life Financial
Group Medical Underwriting
P.O. Box 81344
Wellesley Hills, MA 02481

By fax
781-304-5137

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m, ET