Sun Life Assurance Company of Canada

Group Statement of Health Application

Sun Life Financial®

1 General information

Employer name	Account/policy number	Location	Date effective

Street address	City	State	Zip code

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation

2 Employee information

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth

Street Address	City	State	Zip Code

Marital Status	Social Security Number	Phone number

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary

You need to complete all sections of this form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Your employer will tell you your Maximum Guaranteed Issue amount. See the Statement of health section for details.

3 Benefit elections

Critical Illness coverage*:

Do all persons to be insured currently have a major medical or basic hospital and basic medical plan in force that will not be replaced?..... ☐ Yes ☐ No

If "No," such persons are not eligible for this insurance.

Do all persons to be insured currently have existing specified disease coverage in force or pending with the same or different insurer?..... ☐ Yes ☐ No

If "Yes," such persons are not eligible for this insurance.

	Coverage Amount Elected
Employee coverage:	$ _____
Spouse coverage **:	$ _____

* Critical Illness is a limited policy. The certificate has exclusions and limitations including benefit waiting period for certain conditions which may affect any benefits payable.

** A Spouse may only be covered if you are.

HSA compatible:

Based on the limited available regulatory guidance, Sun Life Assurance Company of Canada ("the Company") believes its "Critical Illness Insurance" is appropriate for use with an HSA and may be purchased when employees and/or their family members are covered under an HDHP. However, the Company cannot provide legal or tax advice. If there are legal or tax questions, we suggest that the employee consult their own legal or tax advisor before purchasing this insurance.

4 Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security number	Date of birth
Spouse / Partner				

5 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 Sun Life Assurance Company of Canada ("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.

Employee: ☐ Male ☐ Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.
Spouse: ☐ Male ☐ Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.

	Employee		**Spouse/ partner**	
	Yes	No	Yes	No
1. Have any of the proposed Insureds ever been diagnosed by a licensed medical professional with, received medical advice for, or sought treatment for any of these ailments:	☐	☐	☐	☐
A. Cirrhosis of the liver or chronic hepatitis, kidney disease or abnormal kidney function, diabetes, chronic disease of the pancreas?	☐	☐	☐	☐
B. Stroke, transient ischemic attack (TIA), aneurysm, paralysis, optic neuritis, disorder of the brain or spinal cord, circulatory disease or disorder, heart attack, angina?	☐	☐	☐	☐
C. Chronic Obstructive Pulmonary Disease (COPD), emphysema, cystic fibrosis, status asthmaticus?	☐	☐	☐	☐
D. Transplant of an organ, stem cells, or bone marrow or advised of the need of transplant of an organ, stem cells, or bone marrow?	☐	☐	☐	☐
E. Cancer or malignancy, leukemia, melanoma, cancer of the bone marrow, benign brain tumor, Hodgkin's disease or non-Hodgkin's lymphoma (not including basal cell carcinoma of the skin that has been removed)?	☐	☐	☐	☐
2. In the last 3 years, have any of the proposed Insureds had an in-situ tumor?	☐	☐	☐	☐
3. In the last 6 months, have any of the proposed Insureds had high blood pressure requiring a change in medication or increase in dosage OR at any last follow up, were any pressure readings 150/95 or greater?	☐	☐	☐	☐
4. Has any of the proposed Insureds ever been diagnosed by a licensed medical professional of: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐

6 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 Application is true, accurate and complete.
- I have read, or had read to me, this completed Application, and understand that any false statements or misrepresentations 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 Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada ("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 Application-file relating to me; (b) correct, amend or delete information in the Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the Application file relating to me is incorrect; and (d) provide me with a copy of my Application.
- The insurance I am enrolling for may have benefit limitations for pre-existing conditions. These limitations will apply even if the conditions were fully disclosed during the enrollment process and I was approved for coverage.

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

6 **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 ("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) 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 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.

X _____ _____

Employee signature — Today's date

X _____ _____

Spouse signature — Today's date

7 Statement of health and authorization information

A medical statement of health application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. A medical statement of health application may also be needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage subject to a medical state of health application will not go into effect until Sun Life Assurance Company of Canada approves it.

I understand that:

- I am requesting coverage under a Group Insurance Policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit a medical statement of health application which is acceptable to Sun Life Assurance Company of Canada. I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the Group Insurance Policy; such coverage will not start until the date I return to work.
- If my spouse is confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the Group Insurance Policy, such coverage will not start until the date he/she is no longer confined and is able to perform their normal activities.

The certificate provides limited benefits. Review your certificate carefully.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X _____ _____

Employee signature Today's date

X _____ _____

Spouse signature Today's date

To the employee: Make a copy of this form for your records.

8 Fraud warnings

General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any 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 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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 may be a crime and subjects such person to criminal and civil penalties.

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 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.

8 **Fraud warnings,** continued

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 with the penalty of 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 are 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
One Sun Life Executive Park]
Wellesley Hills, MA 02481

By e-mail
my.eoi@sunlife.com

www.sunlife.com/us

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