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

96 Worcester Street, Wellesley Hills, MA 02481

Evidence of Insurability instructions

1 Employer instructions

Complete sections 2 and 3 and then give this page and the application to the employee. The employee and/or dependent requesting coverage subject to Evidence of Insurability ("EOI") must fill out the application and include this instructions page with his or her submission. Failure to include the completed instructions page will delay the EOI process.

2 Employee information (to be completed by employer)

Employer name	Group policy number	Division/location	Billing code

Employee name (first, middle initial, last)	Social Security number – –

Please indicate the requested effective date of each coverage subject to EOI:

3 Coverage(s) subject to Evidence of Insurability (to be completed by employer)

Select coverage(s) for which EOI is required. Fill in all applicable fields. Disability Insurance is available to employees only. Need help determining EOI amount? Please see your **Group Policy** and the **Administrator's Guide**.

	Current coverage amount in force (Include any Guaranteed Issue coverage if eligible and any coverage existing prior to this application. If "none," put "$0" in the box.)	**Total amount request** (Enter the total coverage amount requested in dollars)
Employee Basic Life	$	$
Employee Optional Life	$	$
Employee Voluntary Life	$	$
Spouse Basic Life	$	$
Spouse Optional Life	$	$
Spouse Voluntary Life	$	$
Child Basic Life	$	$
Child Optional Life	$	$
Child Voluntary Life	$	$

☐ Short-Term Disability	☐ Long-Term Disability	☐ Long-Term Disability Buy-Up

Name of person completing the above sections (please print)	Signature of person completing the above sections X	Date

4 Employee instructions

Complete, sign, and submit the EOI Application.

1. Complete pages 2 through 6 of the EOI Application. Please remember to sign and date the form.
2. Mail or fax the EOI Application and this instructions page to:

   MAIL TO: Sun Life and Health Insurance Company (U.S.), Group Medical Underwriting, P.O. Box 81344, Wellesley, MA 02481; or

   FAX TO: 781-446-1517

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

Evidence of Insurability Application – Health Questionnaire

- You are applying for coverage from Sun Life and Health Insurance Company (U.S.), which is referred to as "The Company" on this application.
- Complete and return the entire application and the instructions page to Sun Life.

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

	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. To the best of your knowledge and belief, have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) by a licensed member of the medical profession?	☐	☐	☐	☐	☐	☐

To the best of your knowledge and belief, 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
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?	☐	☐	☐	☐	☐	☐

2 Health and personal history, continued

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

To the best of your knowledge and belief, 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
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?	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐

To the best of your knowledge and belief, 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, not including HIV, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	☐	☐	☐	☐	☐	☐

To the best of your knowledge and belief, 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, not including HIV, 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 received treatment in connection with alcohol or drugs?	☐	☐	☐	☐	☐	☐
17. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	☐	☐	☐	☐	☐	☐
18. Are you or one of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐

2 Health and personal history, continued

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

Have you or any of your dependents:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
19. In the last 2 years, engaged in any aviation and related activities, such as skydiving and parachuting, or participated as a professional in athletics or sports?	☐	☐	☐	☐	☐	☐
20. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	☐	☐	☐	☐	☐	☐
21. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional to the best of your knowledge and belief?	☐	☐	☐	☐	☐	☐

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. In addition to being subject to the Incontestability provision of the Certificate, I understand that any material misrepresentation made in the EOI Application 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 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; (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 and Health Insurance Company (U.S.), 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 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 sexually transmitted diseases, mental illness and the use of tobacco, but does not include psychotherapy notes or test results for human immunodeficiency virus (HIV) infection.

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 and Health Insurance Company (U.S.), 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.

5 Fraud warning

Does not apply to Life Insurance

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.

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

Contact us

By mail
Sun Life and Health Insurance Company (U.S.)
Group Medical Underwriting
P.O. Box 81344
Wellesley Hills, MA 02481

By fax
781-446-1517

www.sunlife.com/us

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