Sun Life Assurance Company of Canada

Group Voluntary Accidental Death and Dismemberment Claim Packet

Sun Life Financial℠

Instructions for the Plan Administrator

Use this packet for:

- Employee Voluntary AD&D Claim
- Dependent Voluntary AD&D Claim

Step 1: Submit Notice of Claim

Please have the employee or claimant complete and submit the Notice of Claim to us as soon as you determine that an employee or beneficiary is eligible for Accidental Death and Dismemberment (AD&D) Insurance benefits.

To submit Notice of Claim, the items listed below must be included. These are critical to the timely and accurate determination of eligibility and administration of the claim. We also may request additional information to determine eligibility for benefits:

- Completed Employer's Statement (Section A of this packet)
- Original Voluntary AD&D Insurance enrollment form(s) on file for the claimant
- Verification of eligibility, actively at work status and current salary (most recent payroll record prior to loss)

Send Notice of Claim to:

Sun Life Assurance Company of Canada
Group Life Claims Department, SC 3225
One Sun Life Executive Park
Wellesley Hills, MA 02481

Step 2: Provide Additional Required Sections of the Claim Packet

After you submit the Notice of Claim, please refer to the chart below to determine which sections of the claim packet should be completed and sent to Sun Life Assurance Company of Canada. The beneficiary will be required to complete a Claimant Statement and to submit a Death Certificate (if applicable). Your Policy may not include all of the benefits listed below. Please refer to your Contract for the benefits that apply to you.

Use this chart to determine which sections of the packet you should use for each type of AD&D Claim.

Type of Claim	Provide These Sections
Accidental Dismemberment	Section A Employer's Statement Section C Claimant's Statement for an Accidental Dismemberment Claim Section D Employee's Authorization Section E Physician Statement
Employee Death	Section A Employer's Statement Section B Claimant's Statement for an Accidental Death Claim
Dependent Death	Section A Employer's Statement Section B Claimant's Statement for an Accidental Death Claim

Questions about AD&D Insurance claims? Please call our Customer Service Center at **1-800-247-6875**.

Fraud Warnings

State law requires that we notify you of the following:

For all states except those listed separately:

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 - For Residents of California: 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 - For Residents of Colorado: 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 - For Residents of Florida: 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 - For Residents of Louisiana and Massachusetts: 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 - For Residents of Maryland: 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 as determined by a court of competent jurisdiction.

Fraud Warning - For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning - For Residents of Oklahoma: 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 - For Residents of Oregon, Virginia and Washington: 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.

Sun Life Assurance Company of Canada

Group Voluntary AD&D Claim
Section A: Employer's Statement

Sun Life Financial℠

Please PRINT clearly.

Policyholder Name	Group Policy Number

1. Employee Information

Return to:
Sun Life Assurance
Company of Canada
1 Sun Life Exec. Pk, SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481
Fax: (781) 446-1517

Name (first, middle initial, last)	Date of Birth (m/d/y)	Social Security Number
		| | ▌ | ▌ | | | |

2. Dependent Information

Complete only if submitting a Dependent Life Claim.

Name (first, middle initial, last)	Date of Birth (m/d/y)	Relationship to Employee

3. Type and Amount of Claim

☐ Life	Date of Death (m/d/y)	$
☐ Dependent	Date of Death (m/d/y)	$
☐ Dismemberment	Date of Loss (m/d/y)	$
☐ Other (Describe below)	Date of Disability (m/d/y)	$

If you checked "Other," please describe the type of Accidental Benefit being claimed.

4. Employee Eligibility

Date Hired (m/d/y)	Date Insurance Effective (m/d/y)	Scheduled Hours
Date Premiums Terminated (m/d/y)		
Last Day at Work	Reason ☐ Death ☐ Illness ☐ Layoff ☐ Leave of Absence ☐ Retired	
☐ Hourly Rate per Hour $	☐ Salary Rate per Year $	
☐ Other (i.e.: commissions, bonus, overtime or other compensation)		

5. Signature

Please PRINT clearly.

I certify that the above statements are true and complete. I understand that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

Plan Administrator/Contact (first, middle initial, last)			
Signature X			Date (m/d/y)
Street Address	City	State	Zip Code
Telephone	Fax		

Sun Life Assurance Company of Canada
Group Voluntary AD&D Claim
Section B: Accidental Death Benefit Claimant's Statement

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Instructions

Please provide a certified copy of the Official Certificate of Death to the **employer** along with this form.

Return to:
Sun Life Assurance Company of Canada
1 Sun Life Exec. Park,
SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481
Fax: (781) 446-1517

Complete this form if benefits are legally payable to you as a beneficiary. You are a beneficiary if the insured designated you on his or her most recently dated enrollment or beneficiary designation form. When there is more than one beneficiary, each beneficiary must complete a separate form.

The official police or fire department report of the accident must be furnished to determine if accidental benefits are payable. If a toxicology test is administered, the official results of the test must be provided. We may need other information or reports to determine if the death is accidental under the terms of the group policy.

Please see the next page of this form for additional instructions if:

- The beneficiary is the estate of the insured
- The beneficiary is a minor
- The beneficiary is a trust

1. Information about the Insured

Please PRINT clearly.

Name of Deceased (first, middle initial, last)	Social Security Number	Group Policy Number

2. Information about the Claimant

Name of Claimant (first, middle initial, last)		Social Security Number		Date of Birth (m /d/y)
Street Address	City		State	Zip Code

3. Authorization and Signature

Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number* and that I am not subject to backup withholding under the provisions of the Internal Revenue Code. I certify that the above statements are true and complete and I authorize any physician, hospital or medical facility to release information about the Insured to Sun Life Assurance Company of Canada.

I understand that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

Signature of Claimant X	Date (m/d/y)
Print Name	

* For an individual, the taxpayer identification number is the claimant's Social Security number.

4. Method of Payment

If your claim is approved and your share of proceeds exceeds the minimum set by Sun Life Assurance Company of Canada, we will open a Sun Financial Benefit Account in your name. The Benefit Account is an interest-bearing checking account that gives you immediate access to your Group Life benefits. You simply write a check for all, or a portion, of the proceeds. The Benefit Account is free and is guaranteed by Sun Life Assurance Company of Canada. Funds kept in your Benefit Account earn interest. For the current interest rate, call toll-free, 1-800-225-3950, extension 6930. In Massachusetts, call 1-800-342-3936, extension 6930. Please note: We will use your signature from the preceeding page to verify your signature on any checks that you write.

Important - For Beneficiaries in Arkansas, Kansas, Louisiana, Nevada, North Dakota, and North Carolina:

Beneficiaries in these states can elect to receive the proceeds in a lump sum check. Please indicate your choice below:

☐ I elect the Sun Financial Benefit Account.

☐ I elect a lump sum payment. I am a resident of Arkansas, Kansas, Louisiana, Nevada, North Dakota, or North Carolina.

If the Beneficiary Is the Estate

In some cases, Accidental Death benefits may be payable to the insured's estate. The employer's Group Policy specifies the situations under which benefits are payable to the estate.

Payment of the Accidental Death benefits in these cases will be made to the executor or administrator of the estate. The executor or administrator is appointed by a probate court and is responsible for managing the insured's estate. Please note that a person named as the executor or administrator in the insured's last will & testament **must be** appointed by the court before payment can be made.

The executor or administrator of the estate should complete the Claimant's Statement and provide a certified copy of the **Letters Testamentary** or **Letters of Administration** issued by the probate court. The estate tax identification number (not the Social Security number) is required on the Claimant's Statement.

If the Beneficiary Is a Minor

If the beneficiary is under 18 years of age, under the states **Uniform Transfers to Minors Act** we can transfer life insurance benefits payable to a minor wtih no guardian, if an adult member of the minor's family establishes an account at a bank, trust company, savings institution or credit union in the adults name as custodian for the minor beneficiary. This account must be a custodial account, established for the benefit of the minor under the state's Uniform Transfers to Minors Act.

By providing Sun Life Assurance Company of Canada with written confirmation of the bank's name and address, account name and account number, we can either wire transfer the funds directly to the custodial account or issue a check to the adult as custodian.

Payment can also be made to the court appointed guardian. The **certified certificate of appointment as guardian**, issued by the court, must be furnished.

The guardian/custodian of the minor beneficiary should complete and sign the Claimant's Statement as guardian/custodian of the minor. The minor's Social Security number and date of birth should be indicated on Section B, Part 2 of the Claimant's Statement.

If the Beneficiary Is a Trust

After Sun Life Assurance Company of Canada received notice that the beneficiary of a policy is a Trust, we will prepare and send a **Verification of Trust** form to be completed by the Trustee and returned for file.

The trustee should complete the Claimant's Statement. The trust's Tax Identification Number, (not the Social Security number), is required on the Claimant's Statement.

Sun Life Assurance Company of Canada
Group Voluntary AD&D Claim
Section C: Accidental Dismemberment Benefit Claimant's Statement

Please PRINT clearly.

To be completed by the Insured and returned to Sun Life Assurance Company of Canada – be sure to include the official police or fire department report of the accident and the official results of the toxicology test if one is administered. Additional information may be requested during the claims process.

Return to:
Sun Life Assurance Company of Canada
1 Sun Life Exec. Park,
SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481
Fax: (781) 446-1517

Insured's Name ☐ Male ☐ Female		Date of Birth (m/d/y)	
Street Address	City	State	Zip Code
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced			

1. Information about the Accident

Attach additional pages if more space is needed.

A. Date of Accident (m/d/y)
B. Describe in detail how, when and where the accident occurred.

2. Information about Physicians and Hospitals

A. Please provide the names and addresses of all physicians you have seen for this condition.

Name		Telephone Number	
Street Address	City	State	Zip Code
Specialty		Date of Treatment (m/d/y)	

Name		Telephone Number	
Street Address	City	State	Zip Code
Specialty		Date of Treatment (m/d/y)	

Name		Telephone Number	
Street Address	City	State	Zip Code
Specialty		Date of Treatment (m/d/y)	

2. Information about Physicians and Hospitals (continued)

B. If you have been confined to a hospital as a result of this accident, please provide names and addresses of the hospitals and the confinement dates.

Name of Hospital(s)	Address	Dates of Confinement (m/d/y)

3. Information about Your Loss

A. Claim is made because of loss of:

☐ One limb ☐ Two limbs ☐ Sight in one eye ☐ Sight in both eyes

☐ Thumb and index finger of the same hand ☐ Speech and hearing

☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia ☐ Other_____

Please note that loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, hearing or speech must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints.

4. Signature

I certify that the above statements are true and complete. I understand that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

Employee's Signature X	Date (m/d/y)

Sun Life Assurance Company of Canada
Group Voluntary AD&D Claim
Section D: Claimant's Authorization

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1. Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
1 Sun Life Exec. Park,
SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481
Fax: (781) 446-1517

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care 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; or the Medical Information Bureau, Inc., to disclose my entire medical record and any other protected health information concerning me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affilitates, 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 and 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 entity named above 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.

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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 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.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

2. Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, therapist or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) insurance company; and (c) insurance support organization to disclose any psychotherapy notes relating to me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affilitates, 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 entity named above 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.

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 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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 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.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

3. 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 and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care 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 Assurance Company of Canada ("The Company") its subsidiaries, affilitates, 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 histor;, (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 for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 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.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

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Sun Life Assurance Company of Canada

Group Voluntary AD&D Claim
Section E: Accidental Dismemberment Benefit Attending Physician Statement

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To be completed by the physician and returned to Sun Life Assurance Company of Canada. Please PRINT clearly.

Return to:
Sun Life Assurance
Company of Canada
1 Sun Life Exec. Park,
SC 3225
P.O. Box 81100
Wellesley Hills, MA 02481
Fax: (781) 446-1517

The patient is responsible for any costs associated with the completion of this form.

Name of Patient	Social Security Number		Date of Birth (m/d/y)
Street Address	City	State	Zip Code

1. Losses Suffered by Patient

A. Patient has lost:

☐ One limb ☐ Two limbs

☐ Thumb and index finger of the same hand ☐ Speech *and* hearing

☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia

Please note that loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, hearing or speech must be total and irrecoverable. Loss of thumb and index finger means severance through or above the metacarpophalangeal joints.

B. Date of Accident (m/d/y)

C. Nature of Accident

D. Was the loss due to the accident? . . . . . ☐ Yes ☐ No

2. Details of Treatment

A. Date of First Visit (m/d/y)	B. Date of Last Visit (m/d/y)	C. Date of Last Examination (m/d/y)

D. Frequency of Treatment
☐ Weekly ☐ Monthly ☐ Other If Other, specify frequency:

Include surgery, therapeutic modalities, psychological intervention and medications prescribed, if any.

Nature of Treatment

3. Remarks

4. Physician Information and Signature

Name of Attending Physician	Degree/Specialty	Telephone	
Street Address	City	State	Zip Code

I certify that the above statements are true and complete. I understand that some states require Sun Life Assurance Company of Canada to notify me that 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 be guilty of insurance fraud.

Attending Physician's Signature* X	Date (m/d/y)

* A stamp or signature of a person other than the examining physician is not acceptable.