Sun Life

CM REGENT SOLUTIONS

CM Regent Solutions
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NOTICE OF CLAIM/ACCELERATED BENEFIT LIVING BENEFIT

Attention: Group Life Benefits **Must Be Completed In Full**

Employer's Statement

Name of Claimant (Last, First, M.I.) - **PLEASE PRINT**		Other names by which claimant is known	Basic Annual Earnings at Time of Disability $	Date of Last Salary Change / /
Group Account Number	Effective Date of Full-Time Employment	Effective Date of Employee's Insurance / /	Occupation	
Amount of Employee's Insurance Basic Life $	Supplemental/Voluntary	Date Last Worked / /	Has employee returned to work? (If "Yes," give date) ☐ Yes _____ ☐ No	Have premiums ceased? (If "Yes," give Date) ☐ Yes _____ ☐ No

Reason for Leaving Work
☐ Retired ☐ Absent on Sick Leave ☐ Totally Disabled ☐ Absent Because of Temporary Layoff ☐ No Longer Employed

Important Notice: If on file in your office, please provide us with a copy of the Employee's Enrollment Card, along with any subsequent change of beneficiary or benefit election forms.

Name of Employer	Telephone Number
Address (No., Street, City, State, ZIP Code)	Fax Number

Signature (Authorized Personnel)	Please Print or Type Name and Title of Authorized Personnel	Date Signed

Employee's Statement

Date of Birth	Social Security Number	Sex ☐ Male ☐ Female	Date Last Worked	Telephone Number

Address (No., Street, City, State, ZIP Code)

Please check only one:
☐ I elect to receive the accelerated benefit on my Basic Life only.
☐ I elect to receive the accelerated benefit on my Supplemental/ Voluntary Life only.
☐ I elect to receive the accelerated benefit on both my Basic and my Supplemental or Voluntary Life.

Is this policy subject to any provisions of a divorce decree? ☐ Yes ☐ No

Is there an irrevocable beneficiary on this policy? ☐ Yes ☐ No

If yes, the consent of the irrevocable beneficiary must be obtained agreeing to the payment of the advance benefit in a form which is satisfactory to us.

Describe the condition which is the basis for applying for benefits under the accelerated benefit option.

Names and addresses of all attending physicians/hospitals who treated you for this illness.	Date you first consulted a physician for this condition.
	If you feel additional information would be helpful, please submit it on a separate piece of paper.

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, the Medical Information Bureau or similar organization, insurance or reinsurance company, to disclose or furnish to **Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.))** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. I further authorize any employer, group policyholder or benefits plan administrator to disclose or furnish my employment, financial and wage information to SLHIC (U.S.) and its legal representatives.

I authorize SLHIC (U.S.) to use or disclose this protected health information to any reinsurer and to any person or entity performing a business or legal function on behalf of SLHIC (U.S.) or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect a claim; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date Signed

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.

AK: 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.

AL: 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.

AR, LA, MA, MN, TX and WV: 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.

AZ: 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.

CA: 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.

CO: 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.

DC: 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.

DE, ID and IN: 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.

FL: 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.

KS: 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.

KY: 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.

MD: 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.

ME: 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.

NH: 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: 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 civil fines and criminal penalties.

OH: 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.

OK: 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.

OR: Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

PR: 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.

RI: 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.

TN and WA: 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.

VA: 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.

VT: 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.

Application for Accelerated Benefit Option (Living Benefit)

Group Account Number	Insured's Name	Date of Birth

TO THE PHYSICIAN: The insured is requesting an advance payment of life insurance proceeds due to terminal illness. Your statements are needed to determine eligibility for this advance payment.

History

When did symptoms first appear or accident happen?	Date of Initial Diagnosis	Date of Last Visit

Diagnosis

List diagnoses including complications, if any. _____

Please give current patient status including any objective findings which can include: current X-rays, EKGs and laboratory data (if available, please provide copy of your clinical notes.) PLEASE NOTE: Additional information can be submitted at your discretion.

Is this condition terminal? ☐ Yes ☐ No How long do you expect patient to live? _____

Has patient lost the ability to perform two or more Activities of Daily Living? ☐ Yes ☐ No

On what date did patient become unable to perform two or more of the Activities of Daily Living? _____

Please check off all Activities of Daily Living that patient is unable to perform without substantial assistance from another person:

☐ bathing ☐ eating ☐ dressing

☐ toileting ☐ transferring ☐ continence

Comments: _____

Treatment

Nature of treatment, including surgery and medications prescribed. _____

Progress

Since the initial diagnosis, the patient's condition is: ☐ improved ☐ unchanged ☐ worse

Patient is: ☐ ambulatory ☐ house confined ☐ bed confined ☐ nursing home/hospital confined

Date of hospitalization: _____ _____ _____ _____

Name and address of hospital/nursing facility _____

Competency

Is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

To the best of your knowledge, has a guardian or conservator been appointed? ☐ Yes ☐ No ☐ Unknown

Physician's Verification

Name of Attending Physician (Please Print) _____

Address _____ Phone Number _____

Attending Physician's Signature _____ Date Signed _____