Sun Life Assurance Company of Canada

CM Regent Solutions
Death Benefits Claim Packet – Employee

Instructions for the Plan Administrator

In the event of the death of an insured employee or dependent, please follow these steps as soon as you receive notice of death:

1. Provide the Beneficiary with this claim packet. Instruct the Beneficiary to complete and sign the form and return it to the Employer along with the original certified death certificate*, including cause and manner of death, per the following guidelines:
   - Total benefit claim $10,000 or less: No death certificate required
   - Total benefit claim over $10,000: A copy of the death certificate is acceptable regardless of dollar amount or manner of death
   - An original certified death certificate is required for any death occurring outside the United States or its territories

   *If a death certificate is required, it must list a final cause and manner of death.

2. If this is an Accidental Death, please have the Employer or Beneficiary submit:
   - ☐ an original police report
   - ☐ an original autopsy report
   - ☐ an original toxicology report

   If there is no autopsy or toxicology report done, please send verification from the coroner, medical examiner or admitting hospital.

3. **Collect the completed packet and additional required information and submit to the address below. Overnight mail will be accepted at this location.**

   CM Regent Solutions
   300 Sterling Parkway, Suite 100
   Mechanicsburg, PA 17050

   EBSS@cmregent.com
   Fax: 866.691.6291

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

Fraud Warnings

State law requires that we notify you of the following:

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.

Fraud Warnings continued

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.

Sun Life Assurance Company of Canada

Death Benefits Claim Packet - Employee

Claimant's Statement

Instructions

Return this completed form to the employer along with a certified copy of the Official Death Certificate (if required).

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.

Please see page 8 for additional instructions if:

- The beneficiary is the estate of the insured
- The beneficiary is a trust
- The beneficiary is a minor
- The insured's death has been ruled accidental

1 Information About the Deceased

Please print clearly.

Employer's name			Group policy number
Employee's name (first, middle initial, last) ☐ M ☐ F		Social Security number	Date of birth (m/d/y)
Deceased's name (first, middle initial, last) ☐ M ☐ F			Social Security number
Date of birth (m/d/y)		Relationship	

2 Information About the Beneficiary

For individuals, enter your Social Security number or IRS Individual Taxpayer Identification number. For other entities, enter Employer Identification Number.

Name of beneficiary (first, middle initial, last) or estate		Date of birth (m/d/y)	Relationship
Social Security number or Tax Identification number		Telephone number	
Address of beneficiary or estate	City	State	Zip code
Beneficiary e-mail address			

I certify that the statements made in sections 1 and 2 above are true and complete. I have read or had read to me the fraud warning for my state.

Signature required

Signature of beneficiary or estate representative **X**	**Date (m/d/y)**

3 Information About the Accidental Death (only if applicable)

To be completed by the beneficiary.

1. Did the accidental death occur 100 miles or more from the employee's principal place of residence? ☐ Yes ☐ No
2. Did the accidental death occur while the employee was traveling on business for the employer? ☐ Yes ☐ No
3. Are there any children of the employee in the 12th grade or currently enrolled in an accredited post-secondary institution of higher learning? ☐ Yes ☐ No
4. Did any family member incur any bereavement counseling expenses? ☐ Yes ☐ No

4 Method of Payment

You may choose to receive the life insurance benefit in a lump sum check, direct deposit, or by having it paid into a Sun Life Financial Benefit Account.

The Sun Life Financial Benefit Account is available to all individual beneficiaries who will receive a benefit of $10,000 or more. If the beneficiary is a corporation, trust, or a guardian of a minor, or the benefit is less than $10,000, the benefit will be paid by check.

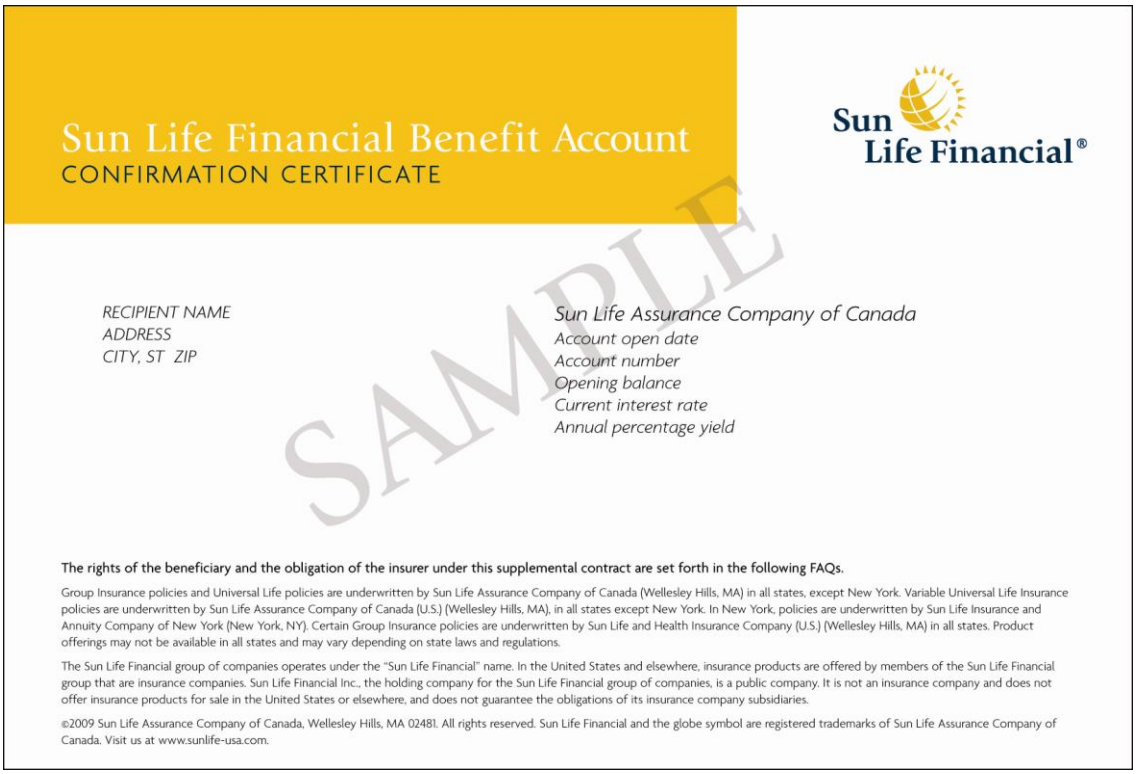
If the beneficiary is a minor and no guardian of the minor's estate has been appointed, the availability of the Sun Life Financial Benefit Account option may vary by state. The Sun Life Financial Benefit Account is immediately available to the guardian of the minor's estate once the guardian has been appointed and to the minor once he or she reaches the age of majority.

After you have read the "Sun Life Financial Benefit Account FAQs," please indicate your choice below. **If no selection is made, benefits will be paid by check. (For policies issued in and for residents of Alaska, Kentucky, Maryland, New Hampshire, New Jersey, and Rhode Island, payment will be made by check.)**

☐ I elect a check

☐ I elect direct deposit (completion of Direct Deposit Authorization required)

☐ I elect the Sun Life Financial Benefit Account



Sun Life Financial Benefit Account
CONFIRMATION CERTIFICATE

Sun Life Financial®

SAMPLE

RECIPIENT NAME
ADDRESS
CITY, ST ZIP

Sun Life Assurance Company of Canada
Account open date
Account number
Opening balance
Current interest rate
Annual percentage yield

The rights of the beneficiary and the obligation of the insurer under this supplemental contract are set forth in the following FAQs.

Group Insurance policies and Universal Life policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York. Variable Universal Life Insurance policies are underwritten by Sun Life Assurance Company of Canada (U.S.) (Wellesley Hills, MA), in all states except New York. In New York, policies are underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY). Certain Group Insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Wellesley Hills, MA) in all states. Product offerings may not be available in all states and may vary depending on state laws and regulations.

The Sun Life Financial group of companies operates under the "Sun Life Financial" name. In the United States and elsewhere, insurance products are offered by members of the Sun Life Financial group that are insurance companies. Sun Life Financial Inc., the holding company for the Sun Life Financial group of companies, is a public company. It is not an insurance company and does not offer insurance products for sale in the United States or elsewhere, and does not guarantee the obligations of its insurance company subsidiaries.

Sun Life Financial Benefit Account: FAQs

The Sun Life Financial Benefit Account is an interest-bearing account established in your name. It is one of Sun Life Financial's methods of payment for life insurance benefit proceeds. The full amount of your life insurance proceeds is available to you at any time. If you elect the Sun Life Financial Benefit Account, any policy settlement options will not be available. You will receive either enclosed in this package, or separately, your own Sun Life Financial Benefit Account Confirmation certificate, which is the supplemental contract for this account, and a draft book, which is similar to a check book. We refer to drafts as checks in these materials. Drafts are similar to checks with some differences; for example, drafts may not credit your bank account as quickly as checks, and drafts may not be accepted by certain retailers.

You can access your proceeds immediately by writing a check. You will also receive monthly statements listing all checks written, the interest credited to your account, any interest rate changes, and any special services that have been requested. (See special fees below.)

This account, which is an obligation of the Sun Life Financial insurance company that issued the life insurance policy, is a secure place for these insurance proceeds.

Sun Life Financial Benefit Account: FAQs *continued*

Review these FAQs and keep this document with your files for future reference.

How does my account work?

You will soon receive a welcome package with a Sun Life Financial Benefit Account opening statement and a supply of checks. You may write a check for the full amount of your account balance at any time or keep all or some of these proceeds in the interest-bearing account. Checks drawn on your Sun Life Financial Benefit Account are payable through BNY Mellon.

How is interest determined and credited?

Interest is earned on proceeds in your Sun Life Financial Benefit Account from the date your account is established until the date checks are cleared. Interest is compounded daily and is credited to your account once a month. We determine the interest rate, at our sole discretion, and may change it periodically. There is no minimum interest rate. (The current rate may be found at https://www.sunlife.com/us/en/about/support/how-do-i/questions-related-to-employee-benefits/). Interest income is reflected in your monthly statement.

We may derive income, in addition to fees charged on the Sun Life Financial Benefit Account, from the investment of the balance of funds in the retained asset account.

Are there any special fees?

We provide you with your first set of checks and free checking services. You will be charged for any special services as follows:

- $15 for each stop payment order • $5 for requests for check copies
- $10 for insufficient funds • $25 for a check book rush request
- $2.35 for a check book reorder • $10 for statement copies

What if I have questions about my account?

Please call our Customer Service Center at 866-223-9149. You also can call this number to request any of the special services listed above.

Is there a minimum check amount?

The minimum amount for which a check may be written on your Sun Life Financial Benefit Account is $250.

Is there a limit on the number of checks I can write?

No, there is no limit.

Can I make deposits into the account?

No, deposits cannot be made into the Sun Life Financial Benefit Account.

How can I keep track of my account?

Each month you will receive a statement listing all checks written, the interest credited to your account, any interest rate changes, and any special services that have been requested.

Is my account subject to unclaimed property laws?

Yes. Your account has been established as the result of payment of your life insurance proceeds and, therefore, continues to be subject to the applicable laws for unclaimed property.

Sun Life Financial monitors the activity on all accounts. If there has been no activity on an account for two years, we will attempt to contact the account owner of record at that time. It is important that you respond to this letter should you receive one.

Is my account insured by the Federal Deposit Insurance Corporation (FDIC)?

No. Your account is not insured by the FDIC. Your account is an obligation of the Sun Life Financial insurance company that issued the life insurance policy and is backed by it. The Sun Life Financial insurance companies enjoy strong financial strength ratings. Independent rating agencies place them among the highest-rated insurance companies in the United States.

How can I reorder checks?

An order form for an additional supply of checks will be included in your welcome package.

Can I designate a beneficiary for the proceeds of this account?

Yes. The package will include a form to designate a beneficiary to whom the proceeds remaining in the account will be payable in the event of your death. If no beneficiary is named, the proceeds will be payable to your estate.

What if my address changes?

Any change of address needs to be communicated in writing. You can use the change of address form included in the package or send a written notice to our Customer Service Department.

Sun Life Financial Benefit Account: FAQs *continued*

Can I stop payment on a check?

Yes. You may order a stop payment by calling our Customer Service Center at 866-223-9149. There is a $15 charge for each stop payment.

Can I request copies of cancelled checks?

If you need a copy of a check, call our Customer Service Center at 866-223-9149. We will send copies of checks to you as soon as possible. There is a $5 charge for each copy.

How is the interest earned on my account reported to the IRS?

At the end of each year, we generate an IRS Form 1099 indicating the annual interest credited to the account. We then send the form to you and to the IRS. You may wish to consult a tax, investment, or other financial adviser regarding tax liability and investment options.

How can I close my account?

You can close your account in one of three ways:

- Simply write a check in the amount of the balance indicated on your most recent statement and bring it to your local bank. Because interest is accrued daily, it may be difficult to know the exact balance. We will send a check containing any remaining interest within 30 days.
- Send a written request to Sun Life Financial Benefit Account, Insurance Services, P.O. Box 535412, Pittsburgh, PA 15253-5412, indicating that you wish to close the account. Please be sure to include your account number. We will mail a check for the full account balance including interest posted to that day.
- Let the balance of the account fall below $250. At the end of each month, accounts with $250 or less are automatically closed. We will send the balance in the account plus accrued interest to you.

Note: The National Association of Insurance Commissioners (NAIC) advises that you can contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com – 703-481-5206) to learn more about coverage and limitations for retained asset accounts by State Guaranty Associations. For further Information, you may also contact your State Department of Insurance. Louisiana residents may write to Louisiana Department of Insurance, 1702 N. Third Street, P.O. Box 94214, Baton Rouge, LA 70802 or call 1-800-259-5300.

5 Certifications and Signature

The IRS does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Cross out item 2 if the IRS has notified you that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Under penalties of perjury, I certify that

1. the Tax Identification Number shown above is correct; and
2. I am not subject to backup withholding because
   a. the IRS has not notified me that I am subject to backup withholding as a result of my failure to report all interest or dividends; or
   b. the IRS has notified me that I am no longer subject to backup withholding.

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Signature X	Date (m/d/y)

6 Additional Instructions

If the Beneficiary is the Estate

In some cases, life insurance 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 life insurance 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 a minor and does not have a guardian of his or her estate, we can pay a life insurance benefit to an adult member of the minor's family up to the limit of your state's Uniform Transfers to Minors Act (UTMA).

For benefits greater than the state UTMA limit, we will pay the benefit to a court appointed guardian of the minor's estate. The guardian must provide us with a certified copy of the court document appointing the guardian and must complete and sign the Claimant's Statement as guardian. The guardian should enter the minor's Social Security number and date of birth on the Claimant's Statement.

If no guardian of the minor's estate is appointed, we will pay the benefit into a Sun Life Financial Benefit Account. The Sun Life Financial Benefit Account is immediately available to the guardian of the estate once the guardian has been appointed and to the minor once he or she reaches the age of majority.

If the Beneficiary is a Trust

After Sun Life Assurance Company of Canada receives 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. We will also accept a certified copy of the Trust documents. 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. Please provide copies of trust document.

If the Insured Died Accidentally

When the insured's death is the result of an accident, accidental death benefits may be payable if:

- **The Group Policy and employee class contain accidental death benefits**
- **The cause of death is "accidental" as defined under the Group Policy**
- **The Policy exclusions do not apply (please refer to the Group Policy)**

The official police or emergency technician 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. If no toxicology test was administered, we will need a letter from the Medical Examiner or admitting hospital or coroner confirming that. We may need other information or reports to determine if the death is accidental under the terms of the Policy.

Sun Life Assurance Company of Canada

Death Benefits Claim Authorization

Authorization for release and disclosure of health-related information

This Authorization complies with the HIPAA Privacy Rule.

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

I HEREBY AUTHORIZE any physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services to, or has medical or health related records or knowledge of, the deceased person named below (the "Insured") or on the Insured's behalf to disclose his or her entire medical record and any other protected health information concerning him or her to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, employees, agents, representatives, third party administrators and reinsurers.

I understand that such information may include records relating to the Insured's 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, 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 the Insured may have made to restrict his or her protected health information do not apply to this Authorization, and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose the Insured's entire medical record without restriction.

I understand that the Company may use the information it obtains to: (a) underwrite any 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; (f) assist the employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about the Insured to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate his or her claim: (a) the Company's subsidiaries and affiliates, (b) the Insured's employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which he or she participates or leave/accommodation services associated with his or her employment; (c) the Insured's treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to his or her claim; (e) his or her insurer, if the Company is acting only as the administrator of his or her claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. The Company will not disclose information it obtains about the Insured 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 re-disclosed 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 of signature; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 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 the deceased Insured	Group policy number
Relationship to the deceased Insured	
Print Name	
Signature X	Date signed (mm/dd/yyyy)

Authorization for release and disclosure of non-health-related information

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services to, or has records or knowledge of the deceased person named below (the "Insured") or on the Insured's 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, affiliates, employees, agents, representatives, third party administrators, and reinsurers, any and all non-health information relating to the Insured, including, but not limited to (a) the Insured's employment earnings; (b) the Insured's occupational duties; (c) the Insured's credit history; (d) insurance benefits the Insured may have received; (e) Social Security benefits the Insured, or the Insured's dependents may be receiving or have received; (f) insurance claims the insured may have filed or insurance coverage he or she may have had; (g) traffic accident reports relating to the Insured; and (h) any other financial information relating to the Insured.

I understand that the Company may use the information it obtains to: (a) underwrite any 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; (f) assist the Insured's employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage the Insured had or applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about the Insured to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate his or her claim: (a) the Company's subsidiaries and affiliates, (b) the Insured's employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which he or she participates or leave/accommodation services associated with his or her employment; (c) the Insured's treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to his or her claim; (e) his or her insurer, if the Company is acting only as the administrator of his or her claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. The Company will not disclose information it obtains about the Insured 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 re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to the Insured's dependents where applicable.

I understand that: (a) this Authorization shall be valid no longer than 24 months from the date of signature below; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 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 the deceased Insured	Group policy number
Relationship to the deceased Insured	
Print Name	
Signature X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Privacy Information Notice – Group Insurance

Sun Life Assurance Company of Canada (“the Company”), a member of the Sun Life group of companies, provides insurance and other financial services to our customers. As part of these services, we are trusted with confidential information. We take this responsibility seriously. All of our employees and our authorized representatives recognize the importance of maintaining confidentiality. The Company gathers information about you to determine fair and reasonable rates for your insurance. Once you are a policyholder, we will need information about you to:

- provide a number of services,
- reinstate a policy; or
- evaluate requests for changes in coverage.

Confidentiality

Insurance companies are among the largest gatherers of information about people. The Company has long been aware of the importance of guarding the confidentiality of such information. We have internal standards and controls governing its use. All employees must follow the procedures outlined in our Code of Business Conduct. Other than as required or allowed by law, the information gathered will not be released to anyone without your authorization or consent.

Collection of Information

We need to obtain information about you to determine whether we can provide the insurance coverage you have requested and to determine a fair and reasonable premium for it. We also use the information we obtain from you to maintain and service your account.

The information collection process begins when you apply for insurance. The application for insurance seeks basic information about you, e.g., your name and address, as well as more detailed information about your health. As part of the application process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

The Company may also request that you submit to certain laboratory tests. Such tests may include an analysis of blood, urine and/or saliva. The testing is done by a licensed laboratory and the results are sent directly to us.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information, the Authorization for Release and Disclosure of Non-Health Related Information and/or the Authorization for Release and Disclosure of Psychotherapy Notes, you authorize us to obtain the medical and non- medical information about you that we need to underwrite your application. Depending upon your particular circumstances, we may collect additional information about you from:

- physicians, health care providers, health plans, medical professionals, hospitals, clinics, laboratories, therapists, pharmacy benefit managers, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or health care related facilities;
- benefit plan administrators;
- employers;
- other insurance companies you have applied to for insurance;
- insurance support organizations;
- financial institutions;
- government agencies, such as the Social Security Administration, the Internal Revenue Service, or the Veteran's Administration;
- public records, such as motor vehicle records; and
- consumer reporting agencies.

Information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

The Underwriting Process

Group medical underwriting is a process by which an insurance company assesses the health of individual applicants to determine if they qualify for insurance coverage above the guarantee issue limit. The information obtained as part of this process may consist of:

- a medical examination;
- blood and urine tests;
- special tests;
- medical records from health care providers or hospitals;
- motor vehicle reports; and/or
- other information collected from the sources described in the above section.

Using this information, the underwriters will further evaluate the risk based on other factors, such as:

- tobacco use;
- driving record; or
- hazardous activities.

After the evaluation process is completed, the underwriter may not accept the risk. If we do not accept the risk, you will be notified. You have the right to request in writing the reason for this action within ninety (90) business days of the date we mail you the notice or other communication of the adverse underwriting decision. You must complete a written authorization and send it to our medical underwriting manager. We will promptly send the requested information. In those states that prohibit the release of sensitive information directly to the prospective Insured, we will do so through a named physician or health department.

Please send this type of request to:

Sun Life Assurance Company of Canada
Group Medical Underwriting
Attention: Medical Underwriting Manager
P.O. Box 81344
Wellesley Hills, MA 02481

Laboratory Testing

To assist in determining your eligibility for insurance, the Company may request some lab testing to be completed. This could include an analysis of blood, urine and/or saliva obtained as part of your insurance exam. The testing is done by a licensed laboratory and the results will be sent directly to us.

The blood testing may include tests for:

- HIV antibody;
- diabetes;
- kidney and liver functions;
- hepatitis;
- cholesterol;
- other tests.

Urine testing may include tests for:

- diabetes;
- kidney function;
- prescription medications;
- drugs of abuse; and
- nicotine/cotinine tests.

As with the rest of your medical information, all test results are treated confidentially and shared only with your authorization and consent, except as required by law. Some states require the reporting of positive tests for HIV and for hepatitis to the state department of health.

Disclosure of Personal Information

When you sign the Authorization for Release and Disclosure of Health Related Information, the Authorization for Release and Disclosure of Non-Health Related Information and/or the Authorization for Release and Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you to:

- any other insurance company you have applied to for insurance;
- third party administrators;
- rehabilitation or vocational professionals;
- your treating physician, psychologist or therapist/counselor, for the purpose of verifying, evaluating, negotiating, determining and/or adjudicating your claim for insurance benefits;
- your employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which you participate or leave/accommodation services associated with your employment;
- other persons or organizations performing medical, investigative, financial or legal services related to your claim;
- the Company's subsidiaries and affiliates; or
- as required or permitted by law.

In the course of underwriting your application or maintaining or servicing your account, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- companies that help us conduct our business or perform services on our behalf;
- your physician or treating medical professional; and
- comply with federal, state or local laws; to respond to a subpoena; or to comply with an inquiry by a governmental agency or regulator.

Access, Correction, Amendment or Deletion of Personal Information

Upon written request to the Company, you can:

- request that we inform you of the nature and substance of the personal information we have about you;
- obtain a copy of the personal information we have about you in our files, and the identity of the medical professional or institutional source(s) of that information, either by mail or in person if you prefer (a fee may be charged to cover the cost of providing a copy of such information);
- request that we disclose to you the identity, if recorded, of those persons to whom we disclosed your personal information within the two (2) years prior to your request (or, if not recorded, the names of those persons to whom we normally disclose such information);
- request that we correct, amend, or delete any personal information about you in our possession; and
- file your own statement of facts if you believe that the personal information we have about you is incorrect.

To take any of these actions, please contact the Company for further instructions. We will respond to your written request within thirty (30) business days from receipt of your request. If we refuse your request to correct, amend, or delete your personal information, we will notify you of the reason(s) for our refusal. If you disagree with our decision, you will have the right to file a concise statement with us setting forth what you think is the correct, relevant or fair information and why you disagree with our refusal to correct, amend or delete your personal information.

Contact us

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

www.sunlife.com/us

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

State Notices

As an addition to the Access, Correction, Amendment or Deletion of Personal Information section:

For residents of Arizona: Upon your request, we will reconsider our underwriting decision based on any corrected information or your own statement of facts.

For residents of California: Please go to www.sunlife.com/us and select the privacy link at the bottom of the page to read our California Privacy Policy and Notice and other related privacy notices.

For residents of Minnesota: If we refuse to correct, amend or delete disputed personal information, you may file an appeal with your Insurance Commissioner.

If a health care professional or a health care institution has provided us health information that the health professional or health care institution has determined and indicates in writing that the release of the health record information is detrimental to your physical or mental health or is likely to cause you to inflict self-harm or to harm another, we may provide the information directly to you only with the approval of the health professional with treatment responsibility for the condition to which the information relates. If approval is not obtained, the information must be provided to the health professional designated by you.

For residents of Montana: Your Insurance Commissioner may review a refusal by us to correct, amend or delete any recorded personal information in order to determine if the information is correct. Your Insurance Commissioner may order us to correct, amend or delete information that the Insurance Commissioner determines is erroneous in your recorded information file.

For residents of Virginia: Disclosure directly to you may be denied if a treating physician, clinical psychologist, or clinical social worker has determined, in the exercise of professional judgment, that the disclosure requested would be reasonably likely to endanger your life or physical safety or that of another or that the information requested makes reference to a person other than a health care provider and disclosure of such information would be reasonably likely to cause substantial harm to the referenced person.

If disclosure to you is denied, you may request we either:

(i) designate a physician, clinical psychologist, or clinical social worker acceptable to us who was not directly involved in the denial, and whose licensure, training, and experience relative to your condition are at least equivalent to that of the physician, clinical psychologist, or clinical social worker who made the original determination, who shall, at our expense, make a judgment as to whether to make the information available to you; or

(ii) if you so request, make the information available, at your expense to a physician, clinical psychologist, or clinical social worker selected by you, whose licensure, training, and experience relative to your condition are at least equivalent to that of the physician, clinical psychologist, or clinical social worker who made the original determination, who shall make a judgment as to whether to make the information available to you.

We shall comply with the judgment of the reviewing physician, clinical psychologist, or clinical social worker made in accordance with the foregoing procedures.

As an addition to the Access, Correction, Amendment or Deletion of Personal Information section:

For residents of New Mexico: Pursuant to the New Mexico Domestic Abuse Insurance Protection Act, and insurance regulations promulgated thereunder, we are required to inform you that the medical and other records provided to us as part of the routine underwriting review may include confidential abuse information. The term “confidential abuse information” includes, for example, information about acts of domestic abuse or abuse status, or the work or home address or telephone number of a victim of domestic abuse. We are prohibited by law from using confidential abuse status as the sole basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating insurance coverage, restricting or excluding coverage or benefits or charging a higher premium. The Domestic Abuse Insurance Protection Act provides you with certain rights to access confidential abuse information received by us and to have that information corrected if it is not accurate.

We are also required to inform you that those who are or have been victims of domestic abuse, or provide shelter, advocacy, counseling or protection to victims of domestic abuse, may request participation as a “protected person” under our location information confidentiality program. This means that we will take measures, as may be required by applicable New Mexico insurance regulations, to help maintain the confidentiality of certain location information in our records. The term “location information” means your address, home telephone number, place of employment, school or other location information. Please notify us, at the contact information provided in The Underwriting Process section, if you wish to participate in this program.

Sun Life Assurance Company of Canada

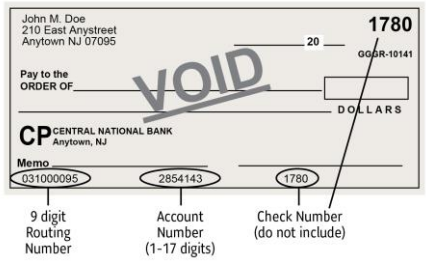
CM Regent Solutions
Direct Deposit Authorization

To enjoy the safety and convenience of Sun Life Assurance Company of Canada's direct deposit services, simply complete this form with your Checking account information and return it to your Sun Life Assurance Company of Canada representative. Please note we cannot receive Savings account information.

1 **Insured information** (please print clearly)

Name of beneficiary			Policy number
Street address	City	State	Zip code
Name of authorized representative signing this form (if applicable)	Title	Phone number	

2 **Financial institution**



Name of individual(s) on Checking Account	
Name of bank or financial institution	City and state of bank or financial institution
Insured/employee's **Routing** number at bank or financial institution	Insured/employee's **Checking Account** number at bank or financial institution

3 **Insured authorization statement**

I hereby authorize Sun Life Assurance Company of Canada, including any of its subsidiaries and affiliates, ("Sun Life") to make all payments due under the policy listed above by direct deposit to the account designated above. This authorization shall be effective until further written notice from me, or another legally authorized representative, is received by Sun Life. I understand that Sun Life needs at least five (5) business days to process any change to this authorization.

I certify that the above listed account information accurately reflects the correct Checking account number and routing number. I agree not to hold Sun Life responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or due to an error on the part of my financial institution, in depositing funds to my account.

To correct any overpayments credited to this account, I hereby authorize and direct the financial institution designated above to debit this account and refund such overpayment to Sun Life.

Signature of beneficiary X	Date (mm/dd/yyyy)
Signature of authorized representative (if applicable) X	Date (mm/dd/yyyy)

Contact us

By mail
CM Regent Solutions
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050

By fax
866.691.6291

By e-mail
EBSS@cmregent.com