

Decatur County Board of Education

SUN LIFE EMPLOYEE BENEFITS

Protect what you love about your life



It's time to enroll in your benefits!

We are pleased to offer you coverage made available through Sun Life as part of your employee benefits program. With benefits from Sun Life, you can stay confident knowing that no matter what unexpected events lie ahead, you have made a plan to help protect your future and your finances.

This booklet contains information about the following coverages being offered to you:

Short Term Disability Insurance

These coverages may be available to your spouse and dependent children as well. Please take the time to review the benefits, your choices, and how much coverage costs, and select the ones that best fit your needs.

Enrolling is easy! Simply fill out your enrollment form and return it to your benefits administrator.

If you have questions about the benefits being offered to you, please reach out to your benefits administrator.

Get to know Sun Life

The coverages offered to you are made available through Sun Life. We are a leading provider of employee benefits in the U.S., and our mission is to help people protect what they love about their lives. You can count on our financial strength and strong global presence. Founded in 1865, Sun Life has operations in 26 countries and serves millions of people around the world.

Voluntary Short-Term Disability Insurance*

Decatur County Board of Education | All Eligible Employees | 934231

Protect your paycheck

Imagine you hurt your back, and your doctor recommends you stay home from work for four weeks. Or imagine you just delivered twins. You can't work, but you have bills to pay. Short-term disability replaces part of your income if you can't work for a short time due to a covered disability. You can use the weekly check to help pay everyday expenses, like your mortgage or rent, utilities, childcare and groceries.

How it works

Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying a portion or all of the cost.

Choose the benefit that best meets your needs and your budget.

Benefits

Weekly benefit after your claim is approved	Get a weekly check of \$50 to \$1,150 , in any \$50 increment you choose, to replace a portion of your income—up to 66.67% of your Total Weekly Earnings—with no medical questions asked up to the Guaranteed Issue amount of \$500 per week.
When benefits begin	Benefits begin as soon as 1 day from the date you are unable to work due to an injury and 8 days due to an illness.
Benefits may be paid for	Up to 26 weeks , as long as you are still unable to work due to a covered disability.
Additional plan information	You're covered for injury or sickness 24 hours a day, seven days a week.

*"1 in 4 workers will miss up to 3 months of work due to illness, injury or pregnancy during their career."***



What did Short-Term Disability insurance mean for Joyce?

Joyce was out apple-picking when she fell off the ladder and broke her ankle. Her injury left her unable to work at her job while she had surgery and recovered at home.

- Joyce filed a claim with Sun Life. We reviewed her medical information and job description and approved her claim.
- Joyce started receiving her weekly benefit, which helped her pay rent, buy groceries and cover the co-pays for doctor visits.
- Six weeks later, Joyce was back at work

Top 5

Short-Term Disability diagnoses:

1. Maternity
2. Musculoskeletal
3. Injury
4. Digestive disorders
5. Cancer

Sun Life claims data, July 2018

Sun Life Assurance Company of Canada
sunlife.com
800-247-6875

Additional considerations

If I have other income	Income from other sources may reduce your benefit amount. These sources may include Social Security benefits, disability benefits from retirement, government plans or state disability income such as California SDI; other group disability plans; no-fault benefits, salary continuance or sick leave, and return-to-work earnings. For more information or to determine if Voluntary STD or Contributory STD is appropriate for you, contact your Benefits Administrator.
If I can work while disabled	Your plan is designed to encourage and support your return to work. If you are able to work part-time for example, you may receive part of your benefit while working.
If I become pregnant	Check with your employer to make sure you are eligible for benefits and let them know when you expect to be out of work on maternity leave. Typically a maternity claim is treated as an illness claim (see "When benefits begin" in the table).

Short-term disability FAQs

What if I have a pre-existing condition?

If you submit a claim within 12 months of your insurance taking effect, or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a claim after becoming disabled?

Check with your employer to make sure you are eligible for benefits. Then, file a claim with Sun Life. We will ask for information from you about your doctor, your income, and your condition. We will ask for medical records and for your doctor to fill out a form about your condition and your expected recovery. You can download forms from our website.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the definition of disability if you're insured when you become disabled.

How is my benefit taxed?

If you pay for your coverage all post-tax, your benefit will not be taxable income or tax reported by us to the IRS. If you pay for your coverage all pre-tax, or if you pay for part of your coverage post-tax and your employer pays for the rest, or if your employer pays the entire premium, some or all of your benefit amount will be taxable income, which will be tax reported on a Form W-2 and it may have FICA tax deductions that reduce the amount we pay you. Please consult with a tax advisor or your employer if you have any questions.

Read the important plan provisions section for more information including limitations and exclusions.

*In Vermont, the product name is Short-Term Income Replacement insurance when the Maximum Benefit Duration elected is less than 26 weeks.

**Realitycheckup.org, Council for Disability Awareness, 2018

Rate Sheet

Employee – Coverage and **Monthly** cost for Short Term Disability.

Rates are effective as of January 1, 2020.

The chart below shows possible coverage amounts and corresponding costs per Monthly pay period.

Locate the annual earnings closest to your salary, without exceeding it. The corresponding coverage amount represents the maximum coverage you could select.

Find your age bracket (as of the effective date of coverage) to determine the associated cost for the coverage amount you choose.

Annual Earnings	Weekly Coverage Amounts	Monthly Coverage Amounts	Age and Cost	
			99+	
\$3,900	\$50	\$216.66	4.45	
\$7,800	\$100	\$433.33	8.90	
\$11,700	\$150	\$650.00	13.35	
\$15,600	\$200	\$866.66	17.80	
\$19,500	\$250	\$1,083.33	22.25	
\$23,399	\$300	\$1,300.00	26.70	
\$27,299	\$350	\$1,516.66	31.15	
\$31,199	\$400	\$1,733.33	35.60	
\$35,099	\$450	\$1,950.00	40.05	
\$38,999	\$500	\$2,166.66	44.50	
\$42,898	\$550	\$2,383.33	48.95	
\$46,798	\$600	\$2,600.00	53.40	
\$50,698	\$650	\$2,816.66	57.85	
\$54,598	\$700	\$3,033.33	62.30	
\$58,498	\$750	\$3,250.00	66.75	
\$62,397	\$800	\$3,466.66	71.20	
\$66,297	\$850	\$3,683.33	75.65	
\$70,197	\$900	\$3,900.00	80.10	
\$74,097	\$950	\$4,116.66	84.55	
\$77,997	\$1,000	\$4,333.33	89.00	
\$81,896	\$1,050	\$4,550.00	93.45	
\$85,796	\$1,100	\$4,766.66	97.90	
\$89,696	\$1,150	\$4,983.33	102.35	

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Short-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection. We will not pay a benefit for any accident or sickness covered by Workers’ Compensation or similar law; or for any work-related illness or injuries unless otherwise stated previously; or if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.).

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, “Sun Life Financial” or “Sun Life”).

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 13-ADD-C-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 12-DI-C-01, 16-DI-C-01, TDBPOLICY-2006, TDI-POLICY, 12-AC-C-01, 16-AC-C-01, 12-SD-C-01, 16-SD-C-01, and 16-CAN-C-01.

© 2018 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.

GVBH-EE-6701

SLPC 29219 08/18 (exp 08/20)



Evidence of Insurability (EOI)

Frequently asked questions

What is Evidence of Insurability?

Your group insurance policy may require Evidence of Insurability (EOI) for you and your dependents. Evidence of Insurability is a statement, or proof, of an employee's or dependent's medical history. We use it to determine whether or not we will provide the benefit you are requesting.

What is the EOI application?

The EOI application is an application on which you and/or your dependent(s) answer "yes" or "no" to questions concerning certain medical conditions. If you answer "yes" to any question(s), you are required to provide specific details of the condition, such as pertinent dates, treatments, and names of physicians. In some cases, a paramedical examination may also be required.

When do I need to submit an EOI application?

You may need to submit an EOI application, if you:

- apply for a coverage amount above the Guaranteed Issue amount,
- declined coverage for yourself or your dependent(s) within the initial eligibility period and are now applying for coverage, or
- enroll yourself or your dependent(s) and then subsequently elect to increase coverage.

Please refer to your benefit highlights page for complete information specific to your plan.

What is the process for submitting an EOI application?

To be considered for coverage, you must complete an EOI application, either online or on paper.

Submit your medical information online

It's the quick, easy, and smart way to submit EOI. And it's completely secure and confidential.

1. Have the following information ready:

- Your group policy number, location, and the amount of coverage for yourself and any dependents who require EOI, and
- Height, weight, and recent medical history for you and any dependents.

2. Go to www.mysunlifebenefits.com

- Click on Apply for Evidence of Insurability Online, follow the instructions, review your answers, and sign your application electronically before you submit. You will receive an official acknowledgment that Sun Life Financial has received your EOI application. If you are approved, you may receive an approval e-mail that same day.

Submit your medical information on paper

If you need a paper application, you can access a printable version at www.mysunlifebenefits.com.

- Click Download Paper Forms
- Click Employee Benefits
- Select Evidence of Insurability
- Select the EOI application for the state in which your company is headquartered

After Sun Life receives and processes your EOI application, you will receive either a final decision or pending notification. If your application is pending, you may be contacted to schedule a medical exam (at Sun Life's expense). Coverage subject to EOI will not go into effect until Sun Life approves your application in writing.

Evidence of Insurability (EOI)

How long does the approval process take?

As soon as we have received a completed online EOI application and as soon as the coverage amount is certified by your employer, often we can issue an approval within minutes and notify you or your employer via our online system or e-mail. For paper applications and applications that require review by a member of our medical underwriting team, the process usually takes five to seven business days. This time range is contingent on you returning a complete EOI application and our ability to obtain the necessary health information.

How will I be notified if I am approved?

If you submit your EOI application online and are approved right away, you will receive an e-mail. If you submit your EOI application via fax or mail, a letter will be sent to your home notifying you of the approval.

How will I be notified if I am denied?

If you are denied the requested coverage, a letter is sent to your home. This letter outlines why you were denied and gives you instructions on how you can appeal the decision.

When does my coverage take effect?

Coverage is effective on the later of the date Sun Life approves your application in writing or the date your coverage is effective under your employer's group insurance policy, provided that you or your dependent(s) are eligible under the group policy.

About privacy and security

In accordance with Sun Life Financial's strict privacy practices, your answers to the Health History portion of the EOI application are completely confidential. Sun Life never shows them to your employer. Also, we do not share your e-mail address or other personal information with any third parties except as permitted or required by law. The website includes state-of-the-art security; any information entered is encrypted and transmitted using Secure Sockets Layer (SSL) technology.

These instructions on how to submit an Evidence of Insurability form apply only to life and disability policies.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 07-SL, 01C-LH-PT, GP-A, GC-A, 12-GP-01, 12-DI-C-01, 13-SD-C-01, 12-SD-C-01, 12-SD-R-01, 13-SD-R-01, 12-AC-C-01, 12-AC-R-01, and 12-AC-R-02. Product offerings may not be available in all states and may vary depending on state laws and regulations.

© 2015 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.

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

☐ Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

1. General Information

Employer Name Decatur County Board of Education	Account / Policy Number 934231	Location Bainbridge, GA	Date Effective
Street Address	City	State GA	Zip Code
Type of activity: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason:		Occupation	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Street Address	City	State	Zip Code
Marital Status	Social Security Number	Phone Number	
Date employed: <input checked="" type="checkbox"/> Full-Time Date:	<input type="checkbox"/> Part-Time Date:	<input type="checkbox"/> Rehire Date:	<input type="checkbox"/> Return from layoff Date:
Current Active Employment Type 40 # of hours <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee Status: <input type="checkbox"/> Management <input checked="" type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired	Salary	

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is. See the Evidence of Insurability section for details.

3. Benefit Elections

Disability Coverage; underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

Short Term Disability Insurance

Choice 1

☒ Elect ☐ Refuse

Coverage amount selected

4. Evidence of Insurability and authorization information

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for higher coverage than the maximum Guaranteed Issue amount.
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier.
- decline coverage and then want it at a later date.

Coverage subject to evidence of insurability will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.). I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

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

Signature of employee X 	Date signed 
--	---

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

5. Employer Information

For Employer Use Only.

Provide the employee's earnings amount below.

Indicate pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

STD Earnings \$	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly
	<input type="checkbox"/> Monthly	<input type="checkbox"/> Bi-Weekly	Number of hours worked per week: _____	

Contact us



By mail

Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.)
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

Sun Life Assurance Company of Canada and Sun Life and Health Insurance Company (U.S.) are members of the Sun Life Financial group of companies.
© 2013 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved.

Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada.

Decatur County Board of Education
Short Term Disability
Evidence of Insurability

Please only complete the EOI if you are purchasing more
than the guaranteed amount shown earlier in the application

Only Complete Employee Section

Questions

Contact
George E Daniel Jr
119 N Donalson Street
Bainbridge, Ga 39817
229-246-3342
229-416-7030
georgedanieljr@gmail.com

Sun Life Financial

Evidence of Insurability instructions

1 Employer instructions

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

2 Employee information (to be completed by employer)

Employer name Decatur County Board of Education	Group policy number 934231	Division/location 1	Billing code
Employee name (first, middle initial, last) ■		Social Security number ■ — —	
Please indicate the requested effective date of each coverage subject to EOI: ■			

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

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

STD BELOW

Current coverage amount in force
(Include any Guaranteed Issue coverage if eligible and any coverage existing prior to this application. If "none," put "\$0" in the box.)

Total amount request
(Enter the total coverage amount requested in dollars)

Employee Basic Life	\$	\$
Employee Optional Life	\$	\$
Employee Voluntary Life	\$	\$
Spouse Basic Life	\$	\$
Spouse Optional Life	\$ N/A	\$ N/A
Spouse Voluntary Life	\$	\$
Child Basic Life	\$	\$
Child Optional Life	\$	\$
Child Voluntary Life	\$	\$

<input checked="" type="checkbox"/> Short-Term Disability ■	<input type="checkbox"/> Long-Term Disability	<input type="checkbox"/> Long-Term Disability Buy-Up
<input type="checkbox"/> Customized Disability		

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

4 Employee instructions

Complete, sign, and submit either the online EOI Application or the printable EOI Application, but not both.

- **Online EOI Application (available for Group policy numbers with six digits or less)**

1. Go to www.mysunlifebenefits.com.
2. Follow the instructions. Enter height, weight, date of birth and medical history for you and any dependents on this application.

- **Printable EOI Application**

1. Complete pages 2 through 5 of the EOI Application. Please remember to sign and date the form.
2. Mail or fax the EOI Application and this instructions page to:

MAIL TO: Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481; or

FAX TO: 781-304-5137

You are required to notify, in writing, Group Medical Underwriting of any changes in your health to the best of your knowledge, between the date you sign the application and the date coverage is approved.

Evidence of Insurability Application – Health Questionnaire

- You are applying for coverage from one of the insurance companies above, outside of New York, which is referred to as “The Company” on this application. Please refer to your Plan Administrator for the correct underwriting company.
- Complete and return the entire application and the instructions page to Sun Life Financial.

2 of 6

2 Health and personal history, continued

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

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:

	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
6. Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, cystic fibrosis or any lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus; connective tissue disease; or fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches, epilepsy, seizures, paralysis, memory loss, intellectual disability, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), multiple sclerosis, muscular dystrophy, or any brain or neurological disorder, chronic infection, or chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the last ten years have you or any of your dependents ever been diagnosed with any of these ailments, received medical advice or sought treatment for:

	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
9. Skin disorder that lasted for more than 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Anxiety, depression or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder; or schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Disorder of the eyes or ears (excluding healed ear infections)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the last ten years have you or any of your dependents:

	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Been off work for more than five consecutive days due to an illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been arrested in connection with alcohol or drugs; or received treatment in connection with alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you or one of your dependents currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you or any of your dependents:

	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
20. In the last 2 years, piloted an aircraft, engaged in motor vehicle racing, auto racing, boat racing, hang gliding, parachuting, climbing, scuba diving, or any similar sport or avocation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3 Details (provide details below for all questions answered “yes.”)

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question number	Applicant name	State and provide details for each condition and activity	Date condition began	Duration of condition and treatment	Physician name, address and phone number	Fully recovered?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide physician information even if you answered “no” to all the questions.

Name and address of physician with your most up-to-date and comprehensive medical records:

4 Acknowledgement, authorization for release and disclosure of health related information and signature

Acknowledgement

I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) (“The Company”) determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.

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

4 Acknowledgement, authorization for release and disclosure of health related information and signature, continued

I AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment, or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Medical Underwriting Department of Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but does not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to [Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

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

5 Fraud warnings

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.

For AL the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For AR, LA, MA, NM, RI, and WV the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For CO the following warning applies: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For the District of Columbia the following notice applies: Any person who knowingly 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.

5 Fraud Warnings, continued

For FL the following notice applies: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For KS the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For ME, TN, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For OH the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For OK the following notice applies: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For OR and VA the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation 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.

For VT the following notice applies: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Contact us



By mail

Sun Life Financial
Group Medical Underwriting
P.O. Box 81344
Wellesley Hills, MA 02481



By fax

781-304-5137



www.sunlife.com/us



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

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

© 2013 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved.

Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada.



You've built a great life. Protect it.

No matter what stage of life you're in, insurance helps protect what you love about your life, giving you the freedom to focus on what matters most.

Talk to your benefits administrator today to learn more about your choices.



One Sun Life Executive Park • Wellesley Hills, MA 02481

The Sun Life Financial group of companies operates under the "Sun Life Financial" name strictly as a marketing name, and no legal significance is expressed or implied. 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 publicly traded holding company for the Sun Life Financial group of companies, is not an insurance company and does not guarantee the obligations of these insurance companies. Each insurance company relies on its own financial strength and claims-paying ability.

© 2016 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.

GVEM-EE-2346t

SLPC 24658 08/16 (exp. 10/20)