Box 1 - HIPAA

Authorization for Release and Disclosure of Health Related Information

I AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, MIB, Inc. (“MIB”) or other medical or healthcare facility that has provided payment, treatment, or services to me or on my behalf, or that has any records or knowledge of me or my health, 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 (“The Company”) its subsidiaries, affiliates, third party administrators, and reinsurers. I authorize The Company, or its reinsurers, to make a brief report of my protected information to MIB.

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.

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.

Box 2 - Acknowledgement

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 applying for coverage more than 31 days past my eligibility date, Evidence of Insurability (EOI) may be required.
- For Life, Long-Term Disability, Short-Term Disability, Critical Illness, and Cancer
- insurance, Evidence of Insurability will be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Life, Long-Term Disability, Short-Term Disability, Critical Illness, and Cancer benefits may require Evidence of Insurability.
- 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, if required for the elected coverage(s), to be approved by The Company for Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant benefit waiting period specified in the certificate of insurance.
- For Dental Insurance plans, I have the right to select any dental care provider of my choice.
- If I elect a Prepaid/DHMO product, I must select a provider included in my plan's directory.
- The dental plan includes a pre-determination provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- Coverages include benefit waiting periods, limitations, and exclusions and a pre-existing conditions provision] that may affect my entitlement to benefits.
- 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.

If you have questions about the benefits provided by this coverage, please contact us at [1-800-247-6875].

Fraud Warning

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.

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

- The information I have provided in the application, and all required supplemental questionnaires, is true, accurate and complete.
- I have read, or had read to me the completed application, and all required supplemental questionnaires, and understand that any false statements or misrepresentations 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 (applicable to Enrollment applicants in FL, LA, MD, NJ, VA and WA, and all EOI applicants).

I also confirm my understanding that:

- My application may be denied and I may be refused insurance if 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 application file relating to me (a fee may be charged); (b) correct, amend or delete information in the application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the application file relating to me is incorrect; and (d) provide me with a copy of my application.

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