Accelerated Benefit Claim Statement—Insured/Spouse

Sun Life Financial®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the state of Alaska, the following statement applies to you:

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.

If you live in the state of Alabama, the following statement applies to you:

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.

If you live in the states of Arkansas, Louisiana, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas or West Virginia, the following statement applies to you:

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.

If you live in the state of Arizona, the following statement applies to you:

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.

If you live in the state of California, the following statement applies to you:

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.

If you live in the state of Colorado, the following statement applies to you:

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.

If you live in the District of Columbia, the following statement applies to you:

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.

If you live in the states of Delaware, Idaho or Indiana, the following statement applies to you:

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.

If you live in the state of Florida, the following statement applies to you:

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.

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York.

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If you live in the state of Kansas, the following statement applies to you:

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.

If you live in the state of Kentucky, the following statement applies to you:

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.

If you live in the state of Maryland, the following statement applies to you:

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.

If you live in the state of Maine, the following statement applies to you:

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.

If you live in the state of New Hampshire, the following statement applies to you:

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.

If you live in the state of New Jersey, the following statement applies to you:

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

If you live in the state of New York, the following statement applies to you:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in the state of Ohio, the following statement applies to you:

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.

If you live in the state of Oklahoma, the following statement applies to you:

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.

If you live in the states of Oregon or Virginia, the following statement applies to you:

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.

If you live in the states of Tennessee or Washington, the following statement applies to you:

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.

If you live in the state of Vermont, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

Accelerated Benefit Claim Statement—Insured/Spouse

Sun Life Financial®

IMPORTANT NOTICE:	RECEIPT OF AN ACCELERATED BENEFIT WILL REDUCE YOUR DEATH BENEFIT. ALSO, IT MAY AFFECT YOUR ELIGIBILITY FOR A STATE OR FEDERAL PROGRAM, SUCH AS MEDICAID, AND BENEFITS MAY BE TAXABLE. YOUR TAX ADVISOR SHOULD BE CONSULTED.

Part I To be completed by Insured (and Spouse, if applying for Dependent Accelerated Benefit) along with the Form W-9 Notice *(on reverse side)*

1. Full name of insured *(Please print.)*	2. Social Security number	3. Date of birth

4. Legal residence *(street, city or town, state, zip code)*

5. Full name of Spouse *(if applying for Dependent Accelerated Benefit)*	6. Social Security number	7. Date of birth

8A. Percentage of amount of life insurance elected _____% *(Subject to the Accelerated Benefit limits set forth in your certificate of insurance.)*	8B. Elected amount of Accelerated Benefit $_____

9. Date illness began	10. Date first consulted physician	11. Describe nature of illness

12. Have you had the same or similar illness before? ☐Yes ☐No If "Yes," please provide dates and details.

13. Name of primary physician(s)	Full address(es)	Date of first and last treatment
Name of hospital(s)	**Full address(es)**	**Date(s) of Confinement**

14. I AUTHORIZE any physician, medical practitioner, hospital, pharmacy, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer, having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Union Security Insurance Company, its legal representative or agency employed by the Company, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Union Security Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Union Security Insurance Company EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

I certify to the correctness of these statements.

Insured's signature _____ DATE

Spouse's signature _____ DATE

by _____ IF INSURED OR SPOUSE CANNOT SIGN RELATIONSHIP

(If Power of Attorney, Guardian or Conservator, please forward a certified copy of the court order evidencing your appointment.)

15. **Disclaimer Statement:** I understand that receipt of an Accelerated Benefit may affect my eligibility for a state or federal program, such as Medicaid, and that these benefits may be taxable. Also, I understand that the death benefit will be reduced if I receive an Accelerated Benefit.

_____ INSURED _____ *BENEFICIARY _____ SPOUSE

*Note: If you have designated an irrevocable beneficiary or if you are requesting an Accelerated Benefit in excess of 50% of your amount of life insurance, your beneficiary's signature is required before an Accelerated Benefit can be paid to you.

IMPORTANT TAX INFORMATION

The Federal income tax laws require us to request that you provide us with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with the Federal income tax laws. See "Guidelines for Determining the Proper Taxpayer Identification Number" on the following page.

Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number (or I am waiting for a number to be issued to me); and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and

3. I am a U.S. citizen or other U.S. person, and

4. I am exempt from FATCA reporting.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

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

Your Signature _____ Date _____

Please print your name _____

GUIDELINES FOR DETERMINING THE PROPER TAXPAYER IDENTIFICATION NUMBER

Social Security numbers have nine digits separated by two hyphens, i.e., 123-45-6789. Employer identification numbers have nine digits separated by one hyphen, i.e. 98-7654321. The guidelines below will help determine the number to give us.

1. **For an individual**
   Give the Social Security number of the individual.

2. **For a custodian account of a minor (Uniform Gifts to Minors Act)**
   Give the Social Security number of the minor.

3. **For an account in the name of a guardian for a designated ward, minor, or incompetent person**
   Give the Social Security number of the ward, minor, or incompetent person

4. **For a valid trust or estate**
   Give the Employer Identification number of trust or estate. (Do not furnish the identification number of the personal representative or trustee.)

5. **For a corporation, religious, charitable, or education organization**
   Give the Employer Identification number of the corporation or organization.

If you do not have a Social Security number or other taxpayer identification number, write “Applied For” in the space for the number, sign and date the form and return to Sun Life Financial. You will have 60 days to obtain a Social Security or other taxpayer identification number and furnish it to us.

1. “Applied For” means you have already applied for or that you intend to apply for a Social Security or other taxpayer identification number soon.

2. You must complete this form even if you are exempt from Backup Withholding to avoid possible erroneous Backup Withholding.

3. If you are a foreign person, complete and submit to us the appropriate, IRS Form W-8.

ARE YOU EXEMPT FROM FATCA REPORTING?

You may be subject to FATCA reporting if you are submitting this form for an account maintained outside of the United States by certain foreign financial institutions. If you are submitting the form for an account you hold in the United States, no FATCA reporting is required. If you are a foreign person, complete and submit to us the appropriate IRS Form W-8. For additional information, see General Instructions to IRS Form W-9.

Part II To be completed by employer

1. Full name of insured *(Please print.)*	2. Certificate number	3. Effective date of insurance: A. of insured B. of dependent	4. Date employed

5. Full-time: ☐Yes ☐No Part-time: ☐Yes ☐No	6. Usual number of hours worked per week	7. Date insured ceased working usual number of hours per week	8. Reason insured ceased working

9. Occupation, position or title	10. Basic salary rate as of the policy determination date immediately preceding the date last worked (Please refer to your Group Policy Schedule.) $ per

11. Legal residence *(street, city, town, state)*	12. Employer's name and full address

13A. Full amount of Term Insurance Full amount of Dep. Life Insurance	13B. Date of last increase in the amount of life insurance	14. Accelerated Benefit amount

15A. Due date of last premium paid by or on behalf of insured	15B. Mode of Premium Payment: ☐Monthly ☐Quarterly ☐Semi-annually ☐Annually

16. Group policy no.- _____

Group participation no.- _____

Account no.- _____

Please forward the original application/beneficiary changes (if maintained by the policyholder).

Name of group policyholder - _____

Telephone number - _____

Name of administrator - _____
(if other than policyholder) *Note: Third Party Administrators must also complete a TPA Form KC3508.*

Telephone number - _____

17. Have you any additional information relating to this claim?

18. We hereby certify that the above facts are true to the best of our knowledge.

Signature - _____ Date - _____
AUTHORIZED SIGNATURE OF THE POLICYHOLDER WITH NO FINANCIAL INTEREST IN THE CLAIM

After you have had your Attending Physician complete the Accelerated Benefit Claim Statement—Supplement, pages 7 and 8 of this form, please return to: **Sun Life Financial**, PO Box 973050, El Paso, Texas 79997-3050.

Accelerated Benefit Claim Statement—Supplement

Sun Life Financial®

The patient must pay any costs for completion of this form.

Name of patient _____ Date of birth _____

Address _____ Telephone _____
STREET CITY STATE ZIP CODE

Employer's name

Plan, Policy or Participation number

Account number

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, law enforcement agency, or employer having medical information with respect to any physical or mental condition and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

_____ _____
SIGNATURE OF PATIENT DATE

ATTENDING PHYSICIAN'S STATEMENT

History

Patient's symptoms result from: ☐Illness ☐Accident

Date symptoms first appeared _____

Dates of treatment:

Date of first visit for this condition _____

Date of most recent visit _____

Date of most recent comprehensive exam _____

Frequency: ☐Weekly ☐Monthly ☐Other *(Specify.)* _____

Name(s) and address(es) of other treating physician(s)

Hospital name _____ Confinement dates _____ through _____

Address _____
STREET CITY STATE ZIP CODE

Diagnoses

Diagnoses *(including any complications)*

Subjective symptoms

Objective findings *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans.)*

Treatment

Describe treatment program, including any surgery or medications.

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York.

Sun Life Financial PO Box 973050 El Paso Texas 79997-3050
T 800.451.4531 F 816.881.8967

Work Capabilities

Are you familiar with the physical and mental demands of the patient's **regular** occupation? ☐Yes ☐No

During what period was the patient **unable** to perform the essential duties of his/her **regular** occupation on a **full-time** basis?

Disability began _____ Ended (or will end) _____ **OR**

☐Never disabled for regular occupation (while under my care) **OR**

☐Disability status unknown

Is patient now able to perform the essential duties of his/her **regular** occupation on a **part-time** basis?
☐Yes ☐No *(If "No," specify which essential job duties the patient is unable to perform.):*

Are you familiar with the patient's education, training, and experience? ☐Yes ☐No

During what period was the patient **unable** to perform **any and every full-time** occupation, in view of his/her training, education, and experience?

Disability began _____ Ended (or will end) _____ **OR**

☐Never disabled for **any and every** occupation (while under my care) **OR**

☐Disability status unknown

Is patient **now** able to perform any work on a **part-time** basis? ☐Yes ☐No

Describe any physical or mental limitations, resulting from this illness/injury, which might interfere with the patient working in **any** occupation.

During what period was the patient affected by these limitations?

Began _____ Ended (or will end) _____ **OR**

☐Unknown

In your opinion, does the claimant possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds? ☐Yes ☐No

Prognosis

Is this patient permanently confined to a nursing home? ☐Yes ☐No ☐Unknown

Nursing home name _____

Address _____
STREET CITY STATE ZIP CODE

Confinement dates _____ through _____

Based upon this patient's medical condition and your current clinical findings, this patient has a Life Expectancy of:

☐Six (6) months or less

☐Six (6) to twelve (12) months

☐Twelve (12) to twenty-four (24) months

☐More than twenty-four (24) months

Name

Physician's name _____ Degree/Specialty _____

Address _____
STREET CITY STATE ZIP CODE

Telephone no. _____ Fax no. _____

Signature _____ Date _____