Sun Life and Health Insurance Company (U.S.)

One Sun Life Executive Park, Wellesley Hills, MA 02481 800-247-6875

Evidence of Insurability Cover Page

Sun Life Financial®

Employer Instructions

Complete this cover page and provide it to the employee. The employee may complete the Evidence of Insurability (EOI) application either online or on paper:

- **Online at www.mysunlifebenefits.com**
  Our secure online system allows employees to provide all of the information needed for Evidence of Insurability in about 10 to 15 minutes. Following completion of the application, the employee receives confirmation by email. The employee then will receive notification of our decision by email or mail.
- **Printable EOI application**
  If submitting the EOI application on paper, the applicant must include this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

Employee/Dependent Information (To be completed by employer)

Employee name (first, middle initial, last)	Group policy number 819927
Social Security number (last four digits) | | |	Approval Requested for ☐ Employee ☐ Spouse/partner ☐ Dependent child(ren): No. of Children:

Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverages for which EOI is required and fill in amounts. Sign and date this page if employee is submitting the printable EOI form.

Need help? See the **Administrator's Guide** and your **Group Policy.**

Life Insurance

	G.I. / Current Amount of Coverage	Requested Amount	Amount Subject to EOI
☐ Employee Basic	$	$	$
☐ Employee Optional	$	$	$
☐ Employee Voluntary	$	$	$
☐ Spouse/Partner Basic	$	$	$
☐ Spouse/Partner Optional	$	$	$
☐ Spouse/Partner Voluntary	$	$	$
☐ Child Basic	$	$	$
☐ Child Optional	$	$	$
☐ Child Voluntary	$	$	$

Other Coverages

☐ Short Term Disability	
☐ Long Term Disability	
☐ Buy-up LTD:	$

Signature of person completing this cover page (Employer) X	Date

Employee Instructions

Complete and submit either the Online EOI Application or the Printable EOI Application, but <u>not both</u>.

- **Online EOI Application**
  1. Go to www.mysunlifebenefits.com and click on Evidence of Insurability.
  2. Follow the instructions on the web site. Enter height weight, date of birth and medical history for you and any dependents on this application. Then, transfer the coverage type and amounts above to the Coverage Information section of the online application.

- **Printable EOI Application**
  1. Complete pages 2 through 4 of the EOI Application according to the instructions. Please remember to sign and date the form.
  2. Mail or Fax the EOI Application and this Employer Cover Page to us:

     MAIL TO: Sun Life and Health Insurance Company (U.S.)
     Group Medical Underwriting
     P.O. Box 81344
     Wellesley Hills, MA 02481

     -or-

     FAX TO: (781) 304-5137

Sun Life and Health Insurance Company (U.S.)

Evidence of Insurability Application – Health Questionnaire

Sun Life Financial®

I Applicant Information (Please print clearly)

Complete and return pages 2 through 4 of this form, along with the employer cover page to:

Sun Life and Health Insurance Company (U.S.)
Group Medical Underwriting
P.O. Box 81344
Wellesley Hills, MA 02481

Fax: (781) 446-1517

Your name (first, middle initial, last)	Name of your employer	Group policy no.	
	PEF Membership Benefits Program	819927	
Your street address	City	State	Zip code
Occupation	Location	E-mail address	
	001		
Social Security number	Daytime phone number	Evening phone number	
– –			

This Application is for: ☐ Employee ☐ Spouse/Partner ☐ Child ☐ Male ☐ Female

Name (if different than above)	Date of birth (m/d/y)	Height	Weight
		ft. in.	lbs.

II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

Important: You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 3 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

1. In the past five years, to the best of your knowledge and belief, have you:

a. Had transplant surgery, other surgery, injuries or been treated in a hospital? ..... ☐ Yes ☐ No
b. Been treated for alcoholism or advised by a physician to change your drinking habits? ..... ☐ Yes ☐ No
c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? ..... ☐ Yes ☐ No
d. Been off work for more than five consecutive days due to illness or injury? ..... ☐ Yes ☐ No
e. Lost 20 lbs. or more over a 12 month period? ..... ☐ Yes ☐ No

2. In the past five years, to the best of your knowledge and belief, have you been diagnosed by a licensed member of the medical profession with or treated for any of the conditions listed below?

a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder ..... ☐ Yes ☐ No
b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder ..... ☐ Yes ☐ No
c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack ..... ☐ Yes ☐ No
d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs ..... ☐ Yes ☐ No
e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder ..... ☐ Yes ☐ No
f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus ..... ☐ Yes ☐ No
g. Sugar in urine, diabetes, kidney or bladder disorder ..... ☐ Yes ☐ No
h. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ..... ☐ Yes ☐ No
i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder except for Human Immunodeficiency Virus (HIV) ..... ☐ Yes ☐ No
j. Disorders of the eyes or ears ..... ☐ Yes ☐ No
k. Chronic fatigue or fibromyalgia ..... ☐ Yes ☐ No

3. To the best of your knowledge and belief, are you currently pregnant? ..... ☐ Yes ☐ No

III Activities

Important: If you answer "Yes" to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

Please answer the following activity questions:

a. Do you participate in aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline? ☐ Yes ☐ No

b. Do you participate in skydiving or parachuting? ☐ Yes ☐ No

c. Do you participate as a professional in athletics or sports? ☐ Yes ☐ No

IV Detail (Provide detail below about any "Yes" answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you need more room, check here ☐ and attach a separate sheet.

V Physician information

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

Physician name			
Street address	City	State	Zip code

VI Signature

Please read and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

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

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application. In addition to being subject to the Incontestability provision of the Certificate, I understand that any material misstatements made in the EOI Application may result in contested coverage under the Group Life Insurance Policy.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if 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; (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 and Health Insurance Company (U.S.), Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481.

I have read or had read to me the Fraud Warning:

Fraud Warning: Does not apply to Life Insurance

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.

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