
Long Term Disability Claim Statement—Conversion



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

If you live in 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 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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

In New York, Sun Life Financial is the brand name for certain insurance products underwritten by Union Security Life Insurance Company of New York, which is licensed solely in New York, has its principal place of business in Fayetteville, NY, and is solely responsible for the financial obligations of its policies.

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Following is the information for claim submission:

Union Security Life Insurance Company of New York

Administered by: **Sun Life Financial** PO Box 972208 El Paso Texas 79997-2208

• T 888.901.6377 • F 866.439.1695 • KCBenefitCenter@sunlife.com

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.

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 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.

INSURED'S IDENTIFYING INFORMATION

New claim

Claim already submitted

1. Full name of insured (<i>Please print.</i>)	2. Certificate number	3. Date of birth
4. Full address	5. Phone number	6. Social Security number
	7. <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced

EMPLOYMENT INFORMATION

9. Name and address of employer from whose policy you converted		10. Occupation
11. Are you currently employed?	12. Current occupation	13. Number of hours worked per week
14. Name and address of current employer		15. Phone number

DISABILITY INFORMATION

16. Nature of sickness or injury (*If due to accident, explain when, where and how it happened.*)

17. Date of first medical treatment for this condition If pregnancy, indicate conception and/or delivery date.	18. Date on which you were first unable to work
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19. Have you engaged in any work, part-time or otherwise, since your sickness or injury began? Yes No
(*If "Yes," please explain and give dates.*)

20. If you have recovered or returned to work, give date.	21. If still totally disabled, when do you expect to return to work?
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22. Names and addresses of all physicians who have been consulted because of this condition

Name	Address	Date of Consultation or Treatment

23. Have you been confined to a hospital for this disability? Yes No (*If "Yes," please complete.*)

Name of Hospital	Address	from	through

OTHER BENEFITS

24. Are you receiving, or are you entitled to receive, benefits from any of the following sources? **Each question must be answered.**

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| A. Salary, wages or commissions? | <input type="checkbox"/> | <input type="checkbox"/> | E. Workers' Compensation or similar legislation? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Retirement or pension plan? | <input type="checkbox"/> | <input type="checkbox"/> | F. Social Security or Railroad Retirement Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Veterans Administration | <input type="checkbox"/> | <input type="checkbox"/> | G. Any federal, state, provincial, municipal or other governmental agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any group insurance, health or welfare plan? | <input type="checkbox"/> | <input type="checkbox"/> | H. No-Fault or other automobile insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | I. Other sources? (<i>Give details below.</i>) | <input type="checkbox"/> | <input type="checkbox"/> |

For each question answered "Yes," please furnish the following information:

Name and Address of source	Group or Individual Basis	Policy or Claim Number (<i>if any</i>)	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid
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For Social Security, Workers' Compensation, and other similar benefits, please furnish a copy of the benefit award (*or denial letter, if applicable*).

AUTHORIZATION

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Life Insurance Company of New York, or its representative, any and all such information. **I understand** Union Security Life Insurance Company of New York may discuss my limitations/restrictions with treating physicians and current or prospective employers as they relate to accommodations and possible return to work. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Life Insurance Company of New York to determine the 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 Life Insurance Company of New York to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

DISABILITY - HIPAA Authorization For Release of Protected Health Information



Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of health care services; hospital, clinic, other medical or medically related facility; insurance or reinsuring company; pharmacist, pharmacy benefits manager, or pharmacy-related services entity; federal, state or local government agency including the Social Security Administration; consumer reporting agency; educational institute; vocational provider; accountant or tax preparer; or employer.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my information as described below:

Information to be disclosed: All medical and non-medical information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: records about my physical and mental health, including diagnosis or treatment for Human Immunodeficiency Virus (HIV), AIDS or other immune disorders, sexually transmitted diseases, use of alcohol and/or drugs; pharmacy records; records regarding Social Security benefits, Worker's Compensation and other insurance claims and benefits, State Disability benefits, and pension benefits; earnings records; tax records and/or records regarding my employment history.

I understand the following:

- The information obtained by use of this authorization will be used by the Companies to evaluate and adjudicate my current disability claim, and may be re-disclosed to the Companies' reinsurer(s). The Companies may release information to my treating physician and current or prospective employers relating to restrictions, accommodations and possible return to work. The information may also be released to (a) any medical, investigative, financial, vocational, or other organization or person, employed by or representing the Companies with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me.
- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it at any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans

This authorization is effective from the date signed below for 24 months.

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

In New York, Sun Life Financial is the brand name for certain insurance products underwritten by Union Security Life Insurance Company of New York, which is licensed solely in New York, has its principal place of business in Fayetteville, NY, and is solely responsible for the financial obligations of its policies.

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