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.

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.

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

Union Security Life Insurance Company of New York
Mail to: **Sun Life Financial** Group Life Benefits PO Box 972208 El Paso Texas 79997-2208
● T 888.901.6377 ● F 866.439.1695 ● lifeclaims@sunlife.com .com www.sunlife.com/us

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.

Authorization to Release Information / Physician Information
*(**Note**: If insured was on an approved waiver of premium claim this does not need to be completed.)*

1. Occasionally in the processing of a claim it becomes necessary for us to contact an outside source for additional information. The legal representative or next of kin of the insured should sign the authorization below to avoid us having to obtain it at a future date.

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, to provide Union Security Insurance Company information concerning advice, care or treatment provided the insured named above or spouse or minor children thereof, any post-mortem examination reports including autopsy, toxicology and investigation. This may include information relating to mental illness, use of drugs or use of alcohol. I authorize any other insurance company to release policy and claim information. I also authorize any employer, group policyholder or benefit plan administrator to provide Union Security Insurance Company with financial or employment related information.

I understand that the information authorized herein will be used by Union Security Insurance Company to evaluate a claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. Information obtained will not be released to any person or organization EXCEPT to reinsuring companies, or other person or organization performing business or legal services in connection with 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.

This authorization is valid from the date signed for the duration of the claim.

Signature _____ Date _____

2. List the name and address of the employee/dependent's primary physician.

Name	Address	Phone number	Dates treated	Conditions

Instructions for Filing a Group Life (or Dependent Life) Claim

Sun Life Financial®

How to complete the Group Life Insurance Claim Form

Union Security Life Insurance Company of New York life claims are administered by Sun Life Financial.

1. Complete Sections A, B, C, D and E of the Group Policyholder Statement portion of the Group Life Insurance Claim Form. In Section C, complete (C1), and (C2) if the claim is for a dependent of an employee.

   For Dependent Life coverage, the employee is usually the beneficiary. See your policy for specific details.

   If the insured was on an approved life disability (waiver of premium) claim, only complete sections A & E of the Group Policyholder Statement and return it along with the Beneficiary Statement(s).

2. Detach the Beneficiary Statement and give it to each beneficiary. Ask each beneficiary to complete and return it to you. *If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Policyholder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you do have. If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator or guardian.)*

3. Return **both** the Group Policyholder Statement and the Beneficiary Statement with the required documents noted below to:

   Postal address:
   Sun Life Financial
   Group Life Benefits
   P.O. Box 972208
   El Paso, Texas 79997-2208

   FAX/Email
   816.881.8967
   LifeClaims@sunlife.com

Documents to submit to Sun Life Financial when filing a life insurance claim

1. Group Policyholder Statement and Beneficiary Statement(s)
2. Copy of the death certificate*
   a. Total benefit claim $10,000 or less: No death certificate required
   b. Total benefit claim over $10,000: Copy of death certificate
   c. Original certified death certificate is required for any certificate issued outside of the U.S.

   * We reserve the right to request an original certified death certificate
3. A copy of the employee's enrollment card, if available
4. A copy of all beneficiary changes, if applicable
5. The certificate of insurance (or policy booklet), if available
6. Legal documentation, for the following situations:
   a. **Beneficiary is an estate, a minor, or not competent to handle financial affairs:** attach a certified copy of the court order appointing the legal representative.
   b. **Beneficiary is a trust:** include a letter verifying that the trust is still in effect. If the trust is testamentary, attach a copy of the will and a certified copy of the letters of testamentary.

      If the beneficiary is a trustee or successor trustee under a trust agreement, send a copy of the trust agreement.
   c. **Beneficiary is no longer living:** include a copy of his/her death certificate.

      Note: If the beneficiary died prior to the insured, the benefits would be payable to the contingent beneficiary. If there is no contingent beneficiary named, we would need a ***Surviving Family Claim Statement*** *(form can be downloaded from our web site: **www.sunlife.com/us**) If the named beneficiary died after the insured, the proceeds would normally be payable to the* ***named beneficiary's estate****. We would need a certified copy of the court order appointing the legal representative of the beneficiary's estate.*
7. If an accidental death claim is being filed, attach all available supporting information such as a police report, medical examiner's report or newspaper clippings.
8. Payroll documentation for **one month** immediately prior to the insured's **last day worked****.

   ** We may request additional payroll information if needed to confirm eligibility and/or calculate the benefit per the Annual Earnings as defined by the policy.

For Dependent Life insurance claims, payroll documentation for one month immediately prior to the date of death is required to verify the employee's status at the time of the death of the dependent.

If you have any questions, please call our Group Life Benefits Team at 888.901.6377 and a representative will assist you.

Life Claims Statement

* Required Field

Sun Life Financial®

This form may be used for both **employee/member** and **dependent** life insurance claims.

Group Policyholder Statement *(To be completed by Employer/Plan Administrator)*

Section A: Employee/Member Information

Name* _____
LAST FIRST MIDDLE INITIAL

Date of birth* _____ Social Security number* _____ State of residence* _____

Address* _____
STREET CITY STATE ZIP

Was Deceased on an approved Life Disability (Waiver of Premium) claim? ☐ Yes ☐ No

If "Yes," Policy number _____ Claim number _____

If Deceased was on a previously approved life disability (Waiver of Premium) claim, complete Sections A and E only.

Section B: Employer/Association Information

Name of Employer/Association _____

Policy number _____ Participation number _____ Account number _____

Employer address _____
STREET CITY STATE ZIP

Location where employed _____
STREET CITY STATE ZIP

Employer telephone number _____ Fax number _____

Web site address _____

Section C: Deceased Information

(C1) *Please complete for all claims.* ☐ Full-time ☐ Part-time Hours worked per week _____

Employee/Member's job title _____

Employee pay status: ☐ Hourly ☐ Salaried Salary on last date worked: $ _____ per ☐ Hr ☐ Wk ☐ Mo ☐ Yr

Employee date of birth _____ Date employee employed _____

Date of death _____

Effective date of employee's coverage _____ Last date employee worked _____

If not actively at work immediately prior to death, what was the reason? *(Check one.)*

☐ Disability ☐ Discharge ☐ Leave of absence ☐ Resigned ☐ Retired ☐ Temporary layoff ☐ Vacation

☐ Other *(Please explain.)* _____

Are Accidental Death benefits being claimed? *(If "Yes," please provide any additional supporting information including police report, Medical Examiner's report and any newspaper articles.)* ☐ Yes ☐ No

Section C2 must be completed for all Dependent Life Insurance Claims.

(C2) Is Deceased a dependent of employee? ☐ Yes ☐ No *(If "No," please skip to Section D.)*

Name of deceased dependent _____
LAST FIRST MIDDLE INITIAL

Dependent's Social Security number _____

Relationship to employee: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

Date of birth _____ Date of death _____

Effective date of dependent coverage _____

Dependent's marital status: ☐ Single ☐ Married ☐ Divorced ☐ Legally separated

Dependent's most recent employer _____

If dependent was disabled, please provide disability date _____

Last date dependent worked _____

If dependent was 19 or over, was the dependent a full-time student? ☐ Yes ☐ No

If you have any questions, please call our Group Life Benefits Team at 888.901.6377 and a representative will assist you.

Name of employee/member _____
LAST FIRST MIDDLE INITIAL

Date of birth _____ Social Security number _____ Policy number _____

Section D: Insurance Coverage/Claimed Information

Type of insurance and amount (being claimed)

☐ Basic Term Life	$
☐ Additional Contributory Life (Supplemental)	$
☐ Voluntary Life	$
☐ Dependent Life (Basic or Voluntary)	$
☐ Accidental Death	$
☐ Dependent Accidental Death	$
☐ Other *(Please specify.)* _____	$
Total	$ 0.00

Was evidence of insurability required on any of the coverage claimed? ☐ Yes ☐ No

Date last premium paid _____ Was insurance in force at date of death? ☐ Yes ☐ No

Section E: Payment Information

Please provide the following information about the beneficiary(ies) your records reflect. Note that if this is for dependent coverage, the beneficiary is normally the employee. If there are more than three beneficiaries, please attach a sheet with additional names and information.

Is there a beneficiary dispute? ☐ Yes ☐ No

Name of Beneficiary #1 _____

Social Security number _____ Relationship to Deceased _____

Name of Beneficiary #2 _____

Social Security number _____ Relationship to Deceased _____

Name of Beneficiary #3 _____

Social Security number _____ Relationship to Deceased _____

Group Policyholder Statement completed by *(name of representative at employer or administrator that completed this form)*

_____
PLEASE PRINT

_____ _____
SIGNATURE (REPRESENTATIVE OF POLICYHOLDER/EMPLOYER) DATE

_____
EMAIL ADDRESS

I hereby certify that the information provided on this form is complete and accurate to the best of my knowledge and I have no financial interest in this claim.

If you have any questions, please call our Group Life Benefits Team at 888.901.6377 and a representative will assist you.

To be completed by each beneficiary *(Please print.)*

Employee/Member's name _____
LAST FIRST MIDDLE INITIAL

Date of birth _____ Social Security number _____ Policy number _____

Section F: Information about you, the beneficiary

Beneficiary's name _____
LAST FIRST MIDDLE INITIAL

Beneficiary's date of birth _____ Beneficiary's Social Security number _____

Beneficiary's address _____
STREET CITY STATE ZIP

Daytime phone _____ Home phone _____

Email address _____

Beneficiary's relationship to Deceased _____

Is beneficiary a U.S. citizen? ☐ Yes ☐ No *(If "No," an IRS Form W-8BEN will be required.)*

Section G: Taxpayer Identification Number and Certification

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 Financlial. 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.

Important note regarding payment of benefits: If you are a personal beneficiary whose share of the proceeds plus interest meets our requirements, a ProviderFund account (an interest-bearing account) will be opened in your name if you so choose. ProviderFund account checks will be supplied upon approval of the claim for benefits allowing you immediate access to your money. For more information, access our ProviderFund brochure at http://www.assurantemployeebenefits.com/816/aebcom/forms/claims/k2796.pdf.

If you have any questions, please call our Group Life Benefits Team at 888.901.6377 and a representative will assist you.

HIPAA Authorization for Release of Protected Health Information – Life

Sun Life Financial®

Insured/Member name _____ SS no. _____

Address _____ City _____ State _____ Zip code _____

Individual who is the Subject of Protected Health Information _____

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

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.

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 protected health information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employment-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

- 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 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. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of personal representative _____

Relationship to insured/member _____

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records.

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).