CITY OF HASTINGS
QUALIFYING LIFE EVENTS &
DEPENDENT COVERAGE

WHAT IS A QUALIFYING LIFE EVENT?

A change in your situation, like getting married, having a baby, or losing health coverage, that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period. Examples of these Qualifying Life Events:

- Loss of health coverage
    - Losing existing health coverage, including job-based, individual, and student plans
    - You Spouse/Domestic Partner Lost His/her Job-Based Insurance
    - Losing eligibility for Medicare, Medicaid, or CHIP
    - Losing cover through a family member
        - Turning 26 and can no long be on a parent's health plan
- Changes in household
    - Getting married or divorced/legally separated
    - Having a baby or adopting a child
    - Death
- Changes in residence
    - Moving to a different ZIP code or Country
    - A student moving to or from the place they attend school
    - A seasonal worker moving to or from the place they both live and work
    - Moving to or from a shelter or transitional housing
- Other qualifying events
    - Changes in your income that affect the coverage you qualify for
    - Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder
    - Becoming a U.S. citizen
    - Leaving incarceration (jail or prison)
    - AmeriCorps members starting or ending their service

It is important to know that losing coverage you have as a dependent doesn't qualify you for a Special Enrollment Period if you voluntarily drop the coverage. You also don't qualify if you or your family member loses coverage because you don't pay your premium.
If you are unsure if your situation qualifies for a life event, please contact human resources.

Source: www.healthcare.gov

WHO IS CONSIDERED TO BE A DEPENDENT?

Legal spouse, biological children and stepchildren, legally adopted children and children placed with you or your covered spouse for adoption, children for whom you or your spouse have been appointed legal guardian, foster children placed with you or your covered spouse, financially dependent grandchildren who live with you or your covered spouse continuously from birth, children allowed to obtain health coverage by a Qualified Medical Child Support Order, disabled dependent children older than age 26 who meet specific criteria, a domestic partner of an unmarried contract holder, children of a domestic partner.

*Please note, not all plans will cover all dependent situations, please contact Human Resources if you are unsure.

IMPORTANT INFORMATION & REMINDERS

- For Blue Cross Blue Shield members, you have up to 60 days to add family members after events such as: birth of a child, adoption of a child (placement), marriage, job loss – you can add your spouse or a child who is under the age of 26.
    - You can remove family member from your plan at any time as long as it correlates with a Qualifying Life Event.
- For Delta Dental members, you have up to 90 days from the Qualifying Event from the date of the Qualifying Event to add a dependent.
- For Avesis members, you have 30 days from the date of the Qualifying Event to add a dependent.
- These enrollment periods are called Special Enrollment Periods. If you chose to not make any changes during this period or fail to submit your changes in time, you will need to wait until the next Open Enrollment Period.
- Even if you currently have a family plan, your dependent still needs to be enrolled for coverage.
    - If you are unsure about your dependent's coverage, please contact Human Resources.

LIFE INSURANCE

- City of Hastings pay for a Basic Life Insurance amount of $50,000 for eligible employees.
    - New employees may sign up for $100,000 on themselves, $25,000 for their spouse, and for the Child life with no health questions.
        - Higher amount may be applied for, but require health questions.
- Benefit eligible employees may apply for additional life insurance for themselves and their spouses subject to proof of good health.
- Life insurance includes Accidental Death & Dismemberment.
- Child Life: Term life insurance protecting your unmarried children for $10,000 each is also available for $1.17 per month. Children are eligible from live birth to age 26.

Attached to this document are the forms needed after a Qualifying Life Event occurs.

You can always review our City's Intranet page for more information.

If you have any questions, please contact Human Resources:

Kelly Murtaugh, Assistant City Administrator
Office: 651-480-2355
Email: Kmurtaugh@hastingsmn.gov

Megan Schlei, Human Resources Technician
Office: 651-480-6159
Email: MSchlei@hastingsmn.gov

Enrollment/Change for Group Coverage
CITY OF HASTINGS

BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

Section A - This part to be completed by Employee

Applicant's Name — Last | First | Middle

Social Security Number ___ - ___ - ___

Applicant's Address — Number | Street | City | State | Zip

Telephone: Home ( ) Work ( ) Other ( )

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Birth Date: m m d d y y

Change in Family Status — Reason for Change: _____ Effective Date: _____

☐ $200 PPO ☐ $1,500 HRA ☐ $2,700 HSA

☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family (Employee/Spouse/Child(ren)

Relationship	LIST ALL ELIGIBLE MEMBERS First, Middle, Last Name	DEPENDENT SOCIAL SECURITY NUMBER	ADD/ CANCEL	BIRTH DATE (mm/dd/yyyy)	Sex M/F
SELF			☐ADD ☐CANCEL		
SPOUSE			☐ADD ☐CANCEL		
			☐ADD ☐CANCEL		
			☐ADD ☐CANCEL		
			☐ADD ☐CANCEL		
			☐ADD ☐CANCEL		

Are you now covered under Medicare Parts A and B? ☐ YES ☐ NO If YES, give Medicare number _____

Is your spouse covered under Medicare Parts A & B? ☐ YES ☐ NO If YES, give Medicare number _____

Do you or any family member applying for coverage have other health care coverage? ☐ YES ☐ NO

Name & address of other insurance company _____

Name of policyholder's employer _____ Group Cert #: _____

Section B - SIGNATURE (This form MUST be signed & dated)

I hereby apply for coverage for which I am or may become eligible under the group contract(s) issued to the City of Hastings. I also authorize the City of Hastings to deduct from my pay any contributions which may be required for the cost of said coverage. I understand and agree that my medical records may be released or obtained by the Plan for purposes reasonably necessary to administer the Plan. To the best of my knowledge, the above information is true and correct.

_____ _____

signature of employee *date*

Section C- FOR EMPLOYER USE ONLY

☐New Hire ☐Change ☐Open Enrollment ☐Other	Date of Employment	Effective Date	Group #	Subgroup #
			CI053	

MEDICARE INFORMATION

Are you or your spose covered by Medicare Part A (Hospital) and Part B (Medical)? ☐ YES (complete section below) ☐ NO

Employee

Effective Date Part A _____ Effective Date Part B _____ Medicare Claim # _____

Eligibility Reason for Medicare ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

Spouse

Effective Date Part A _____ Effective Date Part B _____ Medicare Claim # _____

Eligibility Reason for Medicare ☐ Age ☐ Disability ☐ End-Stage Renal Disease ☐ Disability & End-Stage Renal Disease

COVERAGE CHANGE INFORMATION--CHECK APPROPRIATE BOX(ES) & COMPLETE SESION A, B, & C

Adding Dependents Date of Event

- ☐ Birth/Adoption _____
- ☐ Court Order _____
- ☐ Marriage _____
- ☐ Other Details _____

Cancelling Dependents Date of Event

- ☐ Divorce _____
- ☐ Other (explain) _____

Loss of prior health coverage: Date of Event

- ☐ Other coverage voluntarily terminated _____
- ☐ Group continuation (COBRA) period exhausted _____
- ☐ Employer contribution for coverage terminated _____
- ☐ Coverage terminated due to loss of eligibility _____

- ☐ Address Change
- ☐ Primary care clinic change
- ☐ Name Change
- ☐ Previous Name _____

ENROLLMENT CHANGE FORM SHOULD BE SENT TO:

Blue Cross and Blue Shield of Minnesota and Blue Plus
PO Box 64024
St. Paul, Minnesota
55164-0024

DELTA DENTAL

Delta Dental of Minnesota

Eligibility Enrollment/Update Form

Client Name	Client/Subclient # -

PART A – PLAN ENROLLMENT/UPDATE INFORMATION (please indicate type of update and fill in appropriate information):

Type of Update:	☐ New Enrollment ☐ Reinstatement ☐ Change/Correction to Information ☐ Termination ☐ Transfer	
Transfer From: Client/Subclient # -	**Transfer To:** Client/Subclient # -	**Change is for:** ☐ Subscriber ☐ Dependent ☐ Spouse/Domestic Partner

PART B – FOR MILLENNIUM CHOICE℠ PRODUCT ONLY	**Select a Plan Option:** ☐ Plan Option I – Delta Dental PPO ☐ Plan Option II – Delta Dental Premier

PART C – SUBSCRIBER INFORMATION (please complete for first-time enrollments and updates):

Subscriber Name (Last)	(First)	(Middle initial)	Gender

Social Security Number	Birth Date (Month-Day-Year)	Effective Date (M/D/Y)	Hire Date (M/D/Y)

Street Address	☐ Check here if this is a new address

City	State	Zip Code	Status* ☐ Active ☐ COBRA ☐ Retiree ☐ Surviving

PART D – DEPENDENT INFORMATION (please complete for dependents for first-time enrollments and updates):

Relationship to Employee	Last Name, First Name, M.I. (Include Last Name only if different from Subscriber's)	Gender	Date of Birth (M/D/Y)	Social Security Number-requested but not required**	Status*
Spouse/ Domestic Partner					☐ Legal ☐ Surviving
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student
Dependent Child					☐ Legal ☐ Surviving ☐ Disabled ☐ Sponsored ☐ Full Time Student

*see reverse side for instructions and explanation of codes

**Social security number only requested for dependents with same date of birth

PART E - SUBSCRIBER AND CLIENT SIGNATURE – Sign and date form as verification of your enrollment

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. 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. I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my Employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Delta Dental reserves the right to decline any further enrollment changes.

Do you or your dependents have other dental coverage? Yes No

_____ _____

Name of Carrier Policy/Identification Number

Employee Signature: _____ **Date:** _____

Client Representative Signature _____ **Date:** _____

For Employer Use Only:

Qualifying Event (see next page for list of qualifying events) _____ *Date of Qualifying Event:* _____

Please read the following information carefully before completing the other side of this form. You should fill out this form if you are enrolling for coverage or changing any information from an earlier enrollment. If you have any questions about filling out this form, your human resources or personnel department can help you.

Subscriber Information - This section must be completed for us to process your enrollment or update your records. All information should apply to you, the primary subscriber. Please print clearly or type.

Effective Date: The date that Delta Dental coverage takes effect for you and/or your dependents.

Status Definitions (Please select only one status):

Active: You are a current/active subscriber.

Retiree: You are retired and your employer continues to provide you with dental benefits.

COBRA: You are no longer an active subscriber but you have continued self-paid coverage under COBRA. COBRA requires many employers to offer extended self-paid coverage to certain employees and qualified beneficiaries who lose medical benefits coverage. Please check with your human resources or personnel department.

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Plan Enrollment/Update Information - This section should only be completed if you are: 1) Enrolling yourself or a family member for the first time, or 2) if your benefits were terminated and are not being reinstated or, 3) if you are making changes to your current enrollment information.

New Enrollment: Check for first time enrollment for yourself or your dependents.

Reinstatement: Check for reinstatement coverage for yourself or your dependents.

Change/Corrections: Check if any changes are being submitted on the form.

Termination of Coverage: Check only if you are terminating Delta Dental coverage for yourself or a family member.

Transfers: When transferring from one client to another, all dependents will transfer unless otherwise indicated. This section should also be completed when transferring to COBRA.

When reporting a change or correction, the information that is incorrect or has changed should be listed on the line titled "from" and the correct information should be listed on the line titled "to".

Enrollment/Corrections To Information - This section should be completed when: 1) enrolling dependents or, 2) if you have checked Changes/ Corrections and are changing information that was previously submitted to Delta Dental. Please include both first and last names of any individuals for whom you are enrolling or submitting a change or correction.

Dependent Status Definitions:

Legal: Your current spouse or domestic partner

Surviving: The surviving spouse, domestic partner or child of a deceased subscriber.

Disabled: Your permanently disabled child.

Sponsored: A dependent for whom you are legally responsible. Sponsored dependents could include parents, grandparents and foreign exchange students, but only if specified in your employer's contract with Delta Dental.

Full Time Student: An individual who is your dependent child according to the U.S. Internal Revenue Code. This Student could include your married or unmarried dependent child who is attending a university, college, community college, junior college or trade school on a full-time basis and for whom you provide principal support.

Qualifying Events (for Employer Use Only) -

A – Adoption	L – Loss of Coverage	T - Termination/Reduction of Work Hours
B – Birth	M - Marriage	V – Employee Total Disability
D – Divorce/Legal Separation	O – Open Enrollment	X – Employee Eligible for Medicare
E – Death	S – Dependent No Longer Eligible	

Email: eligibility@mydeltadental.com

Delta Dental
Attention: Eligibility Department
PO Box 30416
Lansing, MI 48909-7916

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Minnesota and its affiliates, (collectively referred to herein as "Delta Dental of Minnesota") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card

If you believe that Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Minnesota, Attn: Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612-351-5104. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-448-3815（TTY：711）. (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-448-3815 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-448-3815 (መስማት ለተሳናቸው: 711). (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး

1-800-448-3815 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815 (TTY: 711). (German)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-800-448-3815 (رقم 711). (Arabic)
ه الصم والبكم:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815 (ATS : 711). (French)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815 (TTY: 711)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815 (TTY: 711). (Tagalog)

ئاگاداری: ئەگەر بە (Kurdish) تۆ بۆ، بەخۆڕایی، زمان یارمەتی خزمەتگوزاریەکانی، دەکەیت قسە کوردی زمانی بە ئەگەر بکە. بەردەستە پ بە1-800-448-3815 (TTY: 711)

توجه: اگر به فارسی زبان گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس1-800-448-3815 (TTY: 711) (Persian / Farsi)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448-3815 （TY:711）まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-448-3815 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-800-448-3815 (TTY: 711) मा कल गर्नुहोस्। (Nepali)

avēsis
a GUARDIAN company

☐ I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	Employee First Name	MI

Date of Birth	Social Security Number	Sex
/ /	- -	☐ Male ☐ Female

Street Address	Apartment No.

City	State	Zip Code
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	Date of Birth
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

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.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Signature	Date
	/ /

A-00713

M-9059/M-9069/M-9086

TO BE COMPLETED BY THE EMPLOYER

☐ New Enrollment	☐ Add ◯ Dependents	☐ Change ◯ Address ◯ Phone ◯ Name ◯ COBRA	☐ Cancel Coverage ◯ Policy Holder ◯ Dependent(s)

Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____

Requested Effective Date	Date of Employment
/ /	/ /

3/18 REV03

Sun Life Financial

Evidence of Insurability instructions

1 Employer instructions

Complete sections 2 and 3 and then give this page and the application to the employee. The employee and/or dependent requesting coverage subject to Evidence of Insurability ("EOI") must fill out the application and include this instructions page with his or her submission. Failure to include the completed instructions page will delay the EOI process.

2 Employee information (to be completed by employer)

Employer name	Group policy number	Division/location	Billing code

Employee name (first, middle initial, last)	Social Security number – –

Please indicate the requested effective date of each coverage subject to EOI:

3 Coverage(s) subject to Evidence of Insurability (to be completed by employer)

Select coverage(s) for which EOI is required. Fill in all applicable fields. Disability Insurance is available to employees only. Need help determining EOI amount? Please see your **Group Policy** and the **Administrator's Guide**.

	Current coverage amount in force (Include any Guaranteed Issue coverage if eligible and any coverage existing prior to this application. If "none," put "$0" in the box.)	**Total amount request** (Enter the total coverage amount requested in dollars)
Employee Basic Life	$ 0	$ 50,000
Employee Optional Life	$	$
Spouse Optional Life	$	$
Child Optional Life	$	$

Name of person completing the above sections	Signature of person completing the above sections X	Date

4 Employee instructions

Complete, sign, and submit either the online EOI Application or] the printable EOI Application, but <u>not both</u>

- **Online EOI Application (available for Group policy numbers with six digits or less)**
  1. Go to mysunlifebenefits.com.
  2. Follow the instructions. Enter height, weight, date of birth and medical history for you and any dependents.]
- **Printable EOI Application**
  1. Complete pages 2 through 5 of the EOI Application. Please remember to sign and date the form.
  2. Mail or fax the EOI Application and this instructions page to:

     MAIL TO: Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481; or

     FAX TO: 781-304-5137

You are required to notify, in writing, Group Medical Underwriting of any changes in your health to the best of your knowledge, between the date you sign the application and the date coverage is approved.

Sun Life Financial

Evidence of Insurability Application – Health Questionnaire

☑ Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

☐ Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

- You are applying for coverage from one of the insurance companies above, outside of New York, which is referred to as "The Company" on this application. Please refer to your Plan Administrator for the correct underwriting company.
- Complete and return the entire application and the instructions page to Sun Life Financial.

1 Employee information (Please print clearly)

Employer name	Group policy number	Division/location	Billing code
Employee name (first, middle initial, last)			
Employee street address	City	State	Zip code
Social Security number – –	Daytime phone number	Evening phone number	
E-mail address	Occupation		

ONLY COMPLETE THIS PORTION OF THE FORM IF YOU ARE REQUESTING OVER $100,000 IN LIFE INSURANCE

2 Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by The Company. No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

	First name	Last name	DOB (mm/dd/yyyy)	Height	Weight	Gender
Employee						☐ M ☐ F
Spouse/ partner						☐ M ☐ F
Child 1						☐ M ☐ F
Child 2						☐ M ☐ F
Child 3						☐ M ☐ F

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
1. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
2. Stroke, transient ischemic attack (TIA), high blood pressure, irregular heart beat, heart murmur, aneurysm, heart attack, angina, elevated cholesterol, or any blood, heart, or blood vessel disorder?	☐	☐	☐	☐	☐	☐

3. Cancer, leukemia, tumor, neoplasm, nodule or polyp (excluding nasal polyp), pre-cancerous condition, or dysplastic nevi?	☐	☐	☐	☐	☐	☐
4. Diabetes, hepatitis, or other disorder of the liver or pancreas; thyroid, pituitary or other endocrine disorder; ulcer, colitis or Crohn's disease, diverticulitis, or other gastrointestinal disorder?	☐	☐	☐	☐	☐	☐
5. Disorder of the kidney, bladder (excluding healed bladder infections or urinary system, or reproductive organs)?	☐	☐	☐	☐	☐	☐

2 Health and personal history

(Complete the following for all persons applying for coverage requiring underwriting)

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
6. Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, cystic fibrosis or any lung or respiratory disorder?	☐	☐	☐	☐	☐	☐
7. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus; connective tissue disease; or fibromyalgia?	☐	☐	☐	☐	☐	☐
8. Headaches, epilepsy, seizures, paralysis, memory loss, intellectual disability, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), multiple sclerosis, muscular dystrophy, or any brain or neurological disorder, chronic infection, or chronic fatigue?	☐	☐	☐	☐	☐	☐

In the last ten years have you or any of your dependents ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
9. Skin disorder that lasted for more than 6 months?	☐	☐	☐	☐	☐	☐
10. Anxiety, depression or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder; or schizophrenia?	☐	☐	☐	☐	☐	☐
11. Disorder of the eyes or ears (excluding healed ear infections)?	☐	☐	☐	☐	☐	☐
12. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	☐	☐	☐	☐	☐	☐

In the last five years have you or any of your dependents:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?	☐	☐	☐	☐	☐	☐
14. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional?	☐	☐	☐	☐	☐	☐
15. Been off work for more than five consecutive days due to an illness or injury?	☐	☐	☐	☐	☐	☐
16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been convicted in connection will alcohol or drugs; or received treatment in connection with alcohol or drugs?	☐	☐	☐	☐	☐	☐
17. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended?	☐	☐	☐	☐	☐	☐
18. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	☐	☐	☐	☐	☐	☐
19. Are you or one of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐

Have you or any of your dependents:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
20. In the last 2 years, piloted an aircraft, engaged in motor vehicle racing, auto racing, boat racing, hang gliding, parachuting, climbing, scuba diving, or any similar sport or avocation?	☐	☐	☐	☐	☐	☐
21. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	☐	☐	☐	☐	☐	☐
22. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional?	☐	☐	☐	☐	☐	☐

3 **Details** (provide details below for all questions answered "yes.")

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question number	Applicant name	State and provide details for each condition and activity	Date condition began	Duration of condition and treatment	Physician name, address and phone number	Fully recovered?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Please provide physician information even if you answered "no" to all the questions.

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

4 **Acknowledgement, authorization for release and disclosure of health related information and signature**

Acknowledgement

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

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation 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.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada or 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 (a fee may be charged); (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 Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481-0003.
I AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment, or services to me or on my behalf, 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 or Sun Life and Health Insurance Company (U.S.) ("The Company") its subsidiaries, affiliates, third party administrators, and reinsurers.

4 Acknowledgement, authorization for release and disclosure of health related information and signature, continued

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.

By my signature below, 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 as long as I am continually insured 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.

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

5 Fraud warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statment 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.

Contact us

By mail
Sun Life Financial
Group Medical Underwriting
P.O. Box 81344
Wellesley Hills, MA 02481

By fax
781-304-5137

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET