

SERFF Tracking Number: SNLF-126273006 State: Arkansas
Filing Company: Sun Life and Health Insurance Company (U.S.) State Tracking Number: 43283
Company Tracking Number: EOI - SLHIC
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term
Product Name: Group Disability Income
Project Name/Number: EOI - SLHIC/

Filing at a Glance

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

Product Name: Group Disability Income SERFF Tr Num: SNLF-126273006 State: Arkansas
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 43283
Closed

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: EOI - SLHIC State Status: Approved-Closed
Long Term

Filing Type: Form

Authors: James Crowley, Lori
Chilcote, Ellen Thibodeau, Linda
Murphy, Frank Jancura

Date Submitted: 08/20/2009

Reviewer(s): Rosalind Minor
Disposition Date: 09/03/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: EOI - SLHIC

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/03/2009

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association

Explanation for Other Group Market Type:

State Status Changed: 09/03/2009

Created By: Lori Chilcote

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Lori Chilcote

Filing Description:

Group Evidence of Insurability Application Form XGR/2627

Dear Sir or Madam:

We are submitting the above application form for your review and approval. The form is new and does not replace any

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form currently on file with your Department. This is an Evidence of Insurability Application form filing only. Benefits and rates on file are not affected.

This form is used when evidence of insurability is required for coverage. Such evidence of insurability may be required for late enrollees or additional amounts of insurance.

The forms are submitted in final print format, subject only to minor variations in color, paper stock, duplexing, shading, fonts and positioning.

This form is exempt from filing in Michigan, the domicile of Sun Life Assurance Company of Canada. This form has been submitted to Connecticut, the domicile of Sun Life and Health Insurance Company (U.S.) and is pending approval. We will notify you when we receive approval.

We request your approval of the enclosed forms. If you have any questions, I may be contacted by email at Lori.chilcote@sunlife.com or by telephone at 860-737-1467.

Sincerely,

Lori Chilcote
State Filing Associate

Company and Contact

Filing Contact Information

Lori Chilcote, Assistant Operations Coordinator Lori.Chilcote@sunlife.com
175 Addison Road 860-737-1467 [Phone]
P.O. Box 725 860-737-6598 [FAX]
Windsor, CT 06095-0725

Filing Company Information

Sun Life and Health Insurance Company (U.S.) CoCode: 80926 State of Domicile: Connecticut
175 Addison Road Group Code: 549 Company Type:
P.O. Box 725 Group Name: State ID Number:
Windsor, CT 06095-0725 FEIN Number: 06-0893662
(860) 737-1000 ext. [Phone]

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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: 1 form x \$20 = \$20
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life and Health Insurance Company (U.S.)	\$20.00	08/20/2009	29995652

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/03/2009	09/03/2009

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Disposition

Disposition Date: 09/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	EOI Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/03/2009	XGR/2627	Application/Enrollment Form	EOI Application	Initial		50.200	XGR2627.pdf

Sun Life Assurance Company of Canada

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

You are applying for coverage from one of the insurance companies above, herein called “The Company.” Please refer to your policy for the correct underwriting company.

1 Employee Information (Please print clearly)

Complete and return pages 1 through 3 of this form, along with the employer instructions to: Sun Life Financial Group Medical Underwriting 15 Rye Street, Suite 210 Portsmouth, NH 03801 Fax: 781-446-1517	Name of your employer [ABC COMPANY]		Group policy number [12345]			
	Employee name (first, middle initial, last) [JOHN DOE]					
	Employee street address [123 MAIN STREET]		City [ANYTOWN]		State [CT]	Zip code [12345]
	Social Security number XXX – XX – [1234]		Daytime phone number [111-222-3333]		Evening phone number [444-555-6666]	
	E-mail address [ABC@GMAIL.COM]		Occupation [WORKER BEE]			

2 Health and Personal History (Complete the following for all persons 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 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	[JOHN]	[DOE]	[1/1/1965]	[6'2"]	[190]	<input checked="" type="checkbox"/> M <input type="checkbox"/> F
Spouse/ Partner						<input type="checkbox"/> M <input type="checkbox"/> F
Child 1						<input type="checkbox"/> M <input type="checkbox"/> F
Child 2						<input type="checkbox"/> M <input type="checkbox"/> F
Child 3						<input type="checkbox"/> M <input type="checkbox"/> F

In the last ten years have you or any of your dependents ever had or been told that you had, received medical advice or sought treatment for:

- Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?
- Stroke, high blood pressure, irregular heart beat, heart murmur, elevated cholesterol or any blood, circulatory or heart disorder?
- Cancer, tumor, neoplasm, polyps or Leukemia?
- Diabetes, hepatitis, liver disorder, thyroid or other endocrine disease, ulcer, colitis, diverticulitis, or other gastrointestinal disorder?
- Disorder of the kidney, bladder or urinary system, reproductive organs or any sexually transmitted disease or disorder?
- Asthma, Bronchitis, COPD, Emphysema, sleep apnea or any lung or respiratory disorder?
- Arthritis, rheumatism, gout, back, neck or disc disorder, disorder of the knee, joints or bones, Lupus or Fibromyalgia?
- Anxiety, depression or any mood, emotional, mental or nervous disorder?
- Headaches, Epilepsy, seizures, paralysis, any brain or neurological disorder, infectious disease or chronic fatigue?

Employee		Spouse/ Partner		Child(ren)	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2 Health and Personal History continued (Complete the following for all persons applying for coverage requiring underwriting)

In the last ten years have you or any of your dependents:

- 10. Disorder of the eyes or ears?
- 11. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?
- 12. Taken prescription medications, been hospitalized, or experienced symptoms for which you have not consulted a medical professional?
- 13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?
- 14. Been off work for more than five consecutive days due to an illness or injury?
- 15. Are you currently pregnant?

Employee		Spouse/ Partner		Child(ren)	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you or any of your dependents:

- 16. Piloted an aircraft, engaged in auto or boat racing, hang gliding, parachuting, scuba diving or any similar sport or avocation?
- 17. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs, used narcotics, barbituates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician or been arrested in connection or received treatment in connection with alcohol or drugs?
- 18. Pled guilty to, pled no contest to, or have been convicted of a felony, or convicted of a major moving violation including DUI, reckless driving or driving to endanger, or had your Driver's license revoked?
- 19. Used any tobacco products, including cigarettes, cigars or chewing tobacco, or used nicotine gum or a nicotine patch?

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3 Detail (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?
[9]	[JOHN DOE]	[MIGRAINES]	[1-1-1999]	1X PER MONTH-IMITREX	[DR SMITH, ANYTOWN, CT 555-555-5555]	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

4 Certification, Authorization for Release and Disclosure of Health Related Information and Signature

Certification

I hereby certify, 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 on Page 4.

I also hereby 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, 15 Rye Street, Suite 210, Portsmouth, NH 03801.

4 Certification, Authorization for Release and Disclosure of Health Related Information and Signature continued

This Authorization complies with the HIPAA Privacy Rule. Incomplete information could delay your application.

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; or (f) Medical Information Bureau, Inc., to disclose my entire medical record and any other protected health information concerning me to 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.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) 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 the Authorization, it may no longer be protected by applicable federal privacy law. I further authorize The Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 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 [JOHN DOE]	Date signed [1-1-2009]
Signature of spouse/partner (If application is for spouse/partner) X	Date signed

Sun Life Assurance Company of Canada Sun Life and Health Insurance Company (U.S.)

Please read the applicable fraud warning below.

State Law requires us to notify you of the following:

Fraud Warning (except as specified below): 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 that person to criminal and civil penalties.

Fraud Warning – CO: 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.

Fraud Warning – District of Columbia: 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.

Fraud Warning – FL: 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.

Fraud Warning – MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – OR: 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 commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

Fraud Warning – VT: 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.

Fraud Warning – VA and WA: 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.

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/03/2009
Comments:			
Attachment:			
Readability Cert.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/03/2009
Bypass Reason:	n/a		
Comments:			

CERTIFICATE OF COMPLIANCE

This is to certify that the text of the submitted forms has achieved a Flesch reading ease score that meets your department's requirements.

Form

Flesch Score

XGR/2710

50.2

**SUN LIFE AND HEALTH INSURANCE COMPANY (U.S.)
SUN LIFE ASSURANCE COMPANY OF CANADA**

Linda W. Murphy

Linda W. Murphy
Compliance Officer