

# Sun Life Insurance and Annuity Company of New York

## Group Life Insurance Transition Statement



### Instructions

1. Complete all sections, including your company information below.
2. Please provide information only about employees with serious illnesses or injuries, rather than temporary conditions such as broken bones, normal pregnancies, influenza or colds.
3. If you need additional space, please attach a separate sheet.
4. Please return this form to your broker or Sun Life Insurance and Annuity Company of New York representative within five business days.

This information will help us transition your Group Life coverage smoothly and help identify any coverage problems for your employees. If you are continuing coverage for employees who are not actively at work, then coverage may be available to those employees on a no loss/no gain basis. Your Sun Life Financial representative or broker can provide you with more details.

### A. Employees Who Are Not Actively At Work

#### About Your Prior Coverage

If your company didn't have Group Life coverage immediately prior to this Sun Life Insurance and Annuity Company of New York policy, please move to section B on page 3. Otherwise, please answer the questions below.

If "No," please move to question 2 on Page 2.  
If "Yes", please answer parts a and b below.

1. Does your prior carrier's Group Life policy have a waiver of premium provision? . . .  Yes  No
  - a. If there are any disabled employees for whom a waiver of premium was not filed within your prior carrier's time limit, please list them below. Please note: if there are any disabled employees who are currently in the elimination period with your prior carrier, be sure to continue premium payments for those individuals to your prior carrier.

Please PRINT clearly.

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

If "Yes," please list any disabled employees, including those currently on waiver of premium with your prior carrier. Please move to question 3 on Page 2.

- b. Does your prior carrier's waiver of premium provision cancel when your group policy terminates? . . . . .  Yes  No

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

**A. Employees Who Are Not Actively At Work (continued)**

If "No" to question 1:

2. Are you continuing Group Life coverage for any disabled employees? . . . . .  Yes  No

If "Yes," please list them below.

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

**About Partially Disabled Employees**

If "Yes," please list them below.

3. Are you continuing Group Life coverage for any employees who receive partial disability benefits? . . . . .  Yes  No

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

**About Employees Over Age 60**

If "Yes," please list them below.

4. Are you continuing Group Life coverage for any disabled employees who became disabled when they were 60 years or older? . . . . .  Yes  No

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

**About Your Company**

5. Sun Life Insurance and Annuity Company of New York's contract allows Group Life coverage to be continued on a premium-paying basis for the following:

Leave of absence or layoff: . . . . . 1 month

Vacation: . . . . . 3 months

Family and Medical Leave: . . . . . 12 weeks

Injury or sickness: . . . . . 12 months

Are you continuing coverage for any employees beyond these times? . . . . .  Yes  No

If "Yes," please list them below.

Name	Date of Birth	Medical Condition	Last Date Worked	Estimated Return To Work	Group Life Amount
					\$
					\$

**B. Employees Who Are Actively At Work**

For confidentiality purposes, please do not list employee names.

Have any eligible employees been treated for a serious medical condition<sup>1</sup> in the past twelve months? .....  Yes  No

If "Yes," please list the medical conditions below.

Medical Condition	Date of Birth	Group Life Amount
		\$
		\$

<sup>1</sup> Some examples of serious medical conditions are: cancer; heart, lung, liver, or kidney disorders; organ or bone marrow transplants; diabetes; immune system disorders; or blood disorders.

**C. Dependent Coverage**

If you cover dependents, please complete this section.

This information will help us transition your Group Life coverage smoothly and help identify any coverage problems for covered dependents.

**About Your Dependent Coverage**

If "Yes," please list them below.

Are there any covered dependents who are confined at home, in the hospital or elsewhere? .....  Yes  No

Name	Date of Birth	Medical Condition	Group Life Amount
			\$
			\$

Thank you for providing this information.

**D. Signature**

Please PRINT clearly.

Policyholder Name		Proposed Effective Date (m/d/y)	
Signature X	Title		Today's Date (m/d/y)

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REP	U/W	MGR