



AUTHORIZATION TO RELEASE INFORMATION

- I certify that the statements on this form are true and complete.
- I authorize the following to exchange information needed for underwriting or administration: Sun Life; my employer; any person or organization who has personal or medical information about me including health professionals and institutions; investigation agencies; insurers; and persons performing services for Sun Life. I also agree to a personal investigation.
- I agree to notify Sun Life promptly if there is a change in my condition that affects my ability to return to work or a change in my monthly income.
- I realize that my disability payments may be reduced if I qualify for a Disability Pension under the Canada Pension Plan or Quebec Pension Plan.
- I agree that a photocopy of this authorization is as valid as an original.

Group Plan No:

50575

Employee ID:

Employee Name:
(please print)



EMPLOYEE SIGNATURE



DATE