Sun Life Assurance Company of Canada

[One Sun Life Executive Park, Wellesley Hills, MA 02481]

Disability Income Application—Virginia State Bar

To apply, please answer the following questions:

- Are you presently a member of the Virginia State Bar? ☐Yes ☐No
- Select coverage desired:
  Monthly Income Benefit: $_____[*May elect $500 to $10,000 in multiples of $100, subject to the restrictions in item 3 below.]*
- Benefit Period - *Check one:* [☐Plan A—Payments up to 2 years ☐Plan B—Payments up to 5 years ☐Plan C—Payments up to age 65]
- Qualifying Period - *Check one:* [☐ [1 month] ☐ [2 months] ☐[3 months] ☐[6 months] ☐[12 months]]
- Cost of Living Adjustment (COLA): ☐Yes ☐No [available only with Plan B or Plan C Benefit Period]
- Payment method: ☐ [Semi-annual]

Complete, date and sign form below. Mail to: Virginia State Bar Members' Insurance Center
[9954 Mayland Drive,Suite 2200
Richmond, VA 23233]

Send no money now. Once accepted, you will receive a billing notice with your Certificate of Insurance.
Application I hereby apply to the Sun Life Assurance Company of Canada for Disability Income Insurance based on the following statements.

1.

Applicant's name *(last, first, middle)*	Sex ☐M ☐F	Age	Date of Birth Mo./Day/ Year	Height (Ft., In.)	Weight (Lbs.)

Street address	City	State	Zip
Mailing address	**City**	**State**	**Zip**

Business phone	Home phone	Applicant's Social Security number

2. Are you working 25 hours per week in the duties of your profession? ☐Yes ☐No (If "No," please provide details below.)

3. The elected Monthly Income Benefit may not exceed an amount which, in combination with benefits payable under all other disability income contracts issued or applied for, exceeds [66 2/3%] of your current monthly earnings.*

   * For lawyers who are not partners, monthly earnings are defined as a 3 year average of the insured's monthly rate of earnings (excluding commissions). Partnership earnings are defined as an average of the prior 3 years ordinary income as reported on Schedule K-1 Partnership Return Income Form 1065, excluding amounts derived from return of capital, interest or dividends.

   What are your current monthly earnings? $_____

   Has any other accident or sickness disability insurance been issued to or applied for by you?..... ☐Yes ☐No

   If "Yes," give details including durations for which benefits are payable, the amounts of monthly benefit and, if applicable, the names of employers or associations through which insurance is provided.

   _____

4. Has any application for insurance ever made by you been postponed, declined, rated or modified? ☐Yes ☐No
(If "Yes," reason?) _____

_____

5. To the best of your knowledge and belief, have you ever had, been treated for, or told you had:
   a. Heart disease, high blood pressure, varicose veins, or disease of or dysfunction of the circulatory system? ☐Yes ☐No
   b. Diabetes, goiter or any disease of or dysfunction of the glands? ☐Yes ☐No
   c. Epilepsy, fainting attacks, mental disorder, or other disease of or dysfunction of the brain or nervous system? ☐Yes ☐No
   d. Fistula, fissure, hemorroids or other disease of or dysfunction of the rectum? ☐Yes ☐No
   e. Cancer or tumor, syphillis or tuberculosis? ☐Yes ☐No
   f. Asthma, pleurisy, or other disease of or dysfunction of the respiratory tract? ☐Yes ☐No
   g. Neck or back strain or injury or hernia? ☐Yes ☐No
   h. Any deformity or loss of limb? ☐Yes ☐No
   i. Any disease of or dysfunction of the reproductive organs? ☐Yes ☐No
   j. Ulcer or any disease of or dysfunction of the stomach, intestines, liver, gall bladder or other disease of or dysfunction of the gastrointestinal tract? ☐Yes ☐No
   k. Sugar in urine, kidney disease, or other disease of or dysfunction of the genitourinary tract? ☐Yes ☐No
   l. Arthritis, rheumatism, or other disease of or dysfunction of the bones? ☐Yes ☐No
   m. Any impairment of sight, speech or hearing, or any disease of or dysfunction of the eye, ear, nose or throat? ☐Yes ☐No
   n. Any surgical operation performed or been advised to have any surgery performed during the past five years? ☐Yes ☐No
   o. Any alcoholic and/or drug addiction and/or abuse? ☐Yes ☐No
   p. AIDS or immunodeficiency disease? ☐Yes ☐No

6. Have you had any medical advisement, examination, consultation or treatment during the past five years, not mentioned in question number 5? If "Yes," please state details in the block portion below. ☐Yes ☐No

7. If you answered "Yes" to any part of question numbers 5 or 6, please complete the following:

Give details to all "Yes" answers. If more space is needed, attach separate sheet.					
Question number	Name of condition	Date occurred	Duration	Degree of recovery	Names and Addresses of Physicians, Hospitals or Clinics Consulted

8. Are you currently using any kind of medically prescribed medication? ☐Yes ☐No
If "Yes," indicate the name of medication and medical condition _____

_____

9. Name and address of family physician _____

_____
Street no. and name City State Zip code

SIGNATURE AND AUTHORIZATION

I understand that if on the effective date of coverage, I am not actively at work on the date I would otherwise become insured, insurance will become effective on the first day I return to work.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by the Virginia State Bar. This coverage will end when my membership terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- Eligibility for initial benefits and any later increases in benefits will require Evidence of Insurability.
- Coverage includes benefit waiting periods, limitations, and exclusions that may affect my entitlement to benefits.
- If I am confined due to an injury or sickness on the date that any initial or increased coverage is scheduled to start, such coverage will not start until the date that I am no longer confined and am able to perform my normal activities.
- 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.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief. I have read or had read to me the fraud warning.

The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

Signature of Applicant _____ Date _____