



OAKTREE

Attachment B

Please return form to HR prior to the start of your leave.

TIME-OFF REQUEST FOR LEAVES OF ABSENCE

To request time off from work during a Leave of Absence please complete, sign and return this form prior to the start of your leave. As always, please call me with questions at (213) 356-3267.

Name: Dana Mookani

Where can you be reached during your proposed leave? Phone: 202-276-2896 E-mail: danamlevy@gmail.com
or dmookani@oaktreecapital.com

Do you participate in: ☒ Health Care FSA ☐ Dependent Care FSA ☐ Neither

I hereby request the following type of leave:

Family Medical Leave Act:

- ☒ For my own disability ☐ To care for a seriously ill family member
☒ For the birth/adoption/foster placement of my child (includes "bonding")

California Family Rights Act:

- ☐ For my own disability ☐ To care for a seriously ill family member
☐ For the birth/adoption/foster placement of my child (includes "bonding")

☐ Pregnancy Disability Leave (PDL)

☐ Military Leave

☐ Personal Leave (Please provide purpose of leave) _____

Should you wish to use accrued, paid time during your leave, please provide the order and quantity (if limited) for each type, below:

Sick Time ☐ 1st ☒ 2nd ☐ 3rd Amount to be used: All

Vacation Time ☐ 1st ☐ 2nd ☒ 3rd Amount to be used: 1

Floating Holiday ☒ 1st ☐ 2nd ☐ 3rd Amount to be used: 1

Time without pay ☐ No ☐ Yes If yes, provide dates: If all other pay options are used up

Regarding accrued time above, would you like to be paid: ☒ for gaps to full pay or ☐ only to cover deductions

I request this leave to be taken (check one): ☒ all at once ☐ intermittently If intermittent, please explain:

_____ For maternity, please provide estimated due date: 3/26/16

Date requested leave to begin: 3/21/16 end date: 7/17/2016

I expect to report back to work for full duty on: 7/18/2016

I understand that I must adhere to the guidelines included in the cover letter which I have received with this form, and that all leaves are subject to approval based upon Oaktree Capital Management policy. I understand that I am required to contact Human Resources at least three (3) days prior to my expected date of return and provide complete and appropriate documentation upon request if I do not return to full duty on that date.

Staff Member Signature: _____ Date: 3/8/16

Routing: Leave Processing/Payroll (TH), Benefit Processing (LJ), LOA Administration (CMS/CC)



LEAVE OF ABSENCE COMPLIANCE CERTIFICATION

I have received, read and understand Oaktree's Code of Ethics (the "Code") and Oaktree's Personal Investment Transaction Policy, as amended, and I agree to abide by the policies and provisions contained therein during my leave of absence, estimated to begin 3/21/16 and to end 7/18/16, including but not limited to the required pre-approval of personal investment transactions and political activity and the approval of outside business activities and director and officer positions.

<u>Dana Mookani</u>	<u>[Signature]</u>	<u>3/8/16</u>
Name (Print)	Signature	Date

I. Personal Investment Transactions

- **Preclearance:** Personal investment transaction pre-approval requests should be submitted within Personal Trading Control Center (PTCC), Oaktree's automated personal trading system. If you will not have access to Oaktree systems, please use the PTCC URL <https://secure.complysci.com> and your password for direct access to the trading system.

Pre-approval request status notifications are sent to your Oaktree email. If you will not have access to your Oaktree email, pre-approval status is available on your PTCC dashboard under "Trade/IPO/Private Placement Preclearance Requests." A successfully submitted request will show as pending until Compliance processes the request. After a trade request has been processed, the status will change to "approved" or "denied." By clicking on the "Request Date" hyperlink you can view your window period for trading and security details.

- **Personal Trading Quarterly Certifications:** Should you or your Related Person(s) conduct any personal trading during your leave of absence, you will be subject to quarterly certification requirements and deadlines while on leave. Thus, you will be required to log on to PTCC during your leave and complete your quarterly certification. If you or your Related Persons do not conduct any personal trading during your leave of absence, you may complete any missed certifications upon your return.

II. Political Activity, Outside Business Activities and Outside Director and Officer Positions

- Participation in Political Activity, as defined in the Code, by you or your Related Person(s) requires prior approval from the Chief Compliance Officer or an Approving Officer. Volunteering that does not include fundraising or coordinating campaign contributions does not require pre-approval. Pre-approval requests should be submitted via My Compliance Center.
- To participate in Outside Business Activities subject to the Code, you are required to obtain approval from your Department Head and the Chief Compliance Officer or an Approving Officer. To request approval, submit a Request for Outside Business Activity form via My Compliance Center.
- In the event that you wish to serve as a director or officer, or in a similar capacity, of a company that is not an Oaktree portfolio company, you must obtain approval from your Department Head or an Approving Officer, subject to certain exceptions provided by the Code (e.g., private family corporations and charitable,



CONFIDENTIAL

COMPUTER ACCEPTABLE USE POLICY

I have received, read and understand Oaktree's Computer Acceptable Use Policy, effective March 18, 2014 and as amended. I agree to abide by the policy and acknowledge that my computer systems access may be interrupted if I do not confirm my acceptance after reading any updated versions during my leave of absence, estimated to begin 3/21/16 and to end 7/18/16, within the allowed time.

Dana Mookni

Name (Print)

Signature

3/18/16

Date

- The purpose of the Oaktree Computer Acceptable Use Policy is to outline the proper use of computer systems at Oaktree. This policy is intended, among other things, to ensure compliance with applicable law and minimize the risk of degradation of our network and computer systems as a result of inappropriate use, virus attacks, or breaches of our systems and security.

- The Computer Acceptable Use policy includes the following policies:

E-mail Policy – purpose is to establish the rules for the use of Oaktree e-mail for the sending, receiving, or storing of electronic mail.

Internet Use Policy – purpose is to establish prudent and acceptable practices regarding the use of the Internet and the Intranet.

Social Media Policy – purpose is to establish prudent and acceptable practices regarding the use of social media sites and to educate individuals who use social media sites of the responsibilities associated with such use. You are also required to adhere to the social media site requirements, whether access is made through an Oaktree computer/network or a personal computer/network.

Network Access Policy – purpose is to establish the rules for the access and use of the Oaktree network infrastructure. These rules are necessary to preserve the integrity, availability and confidentiality of Confidential Information.

Password Policy – purpose is to establish the rules for the creation, distribution, safeguarding, termination, and reclamation of Oaktree user authentication mechanisms.

Mobile Computing Policy – purpose is to establish the rules for the use of mobile computing devices and their connection to the network. These rules are necessary to preserve the integrity, availability, and confidentiality of Oaktree information.

- Should you have any questions concerning the policy while on leave, please contact:
Bob Frank at (213)830-6287 or bfrank@oaktreecapital.com

Certification of Physician or Practitioner for PDL or PDL/FMLAEmployee's Name: Dana MoolaniDate employee disabled due to pregnancy, childbirth, or related medical condition: 3/21/2016I anticipate that the above named employee will be disabled for: 6 WKS. - IF PATIENT (amount of time) or
expected to return to work on date: 5/9/2016 HAS A VAGINAL DELIVERY

I hereby certify that the employee named above is disabled because of pregnancy, childbirth or related medical conditions as of the date stated above and that the employee is unable to work at all or is unable to perform any one or more of the essential functions of her position, without undue risk to herself or to other persons, or to the successful completion of her pregnancy.

Signature of Physician or Practitioner [Signature] Date 3/11/2016

Physician or Practitioner Information:

Physician's or Practitioner's Name DR. JACQUES MORITZ, MD (LOMA OB/GYN)Address 233 BROADWAY STE #2350City NY State NY Zip 10279Telephone (212) 962-5662

This form must be returned to:

Christine Sowers (fax: 213-830-8539)

Representative

Oaktree Capital Management, L.P.

Company Name

333 S. Grand Avenue, 28th Floor

Address

City Los AngelesState CAZip 90071 -

City

State

Zip

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Instructions

- ☐ Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**
- Employer Statement
 - Employee Statement
 - Attending Physician Statement
 - Authorization Statements
- An STD claim should be submitted once a disability absence has actually begun and will extend beyond the required elimination period.
- ☒ Prefill the Group STD policy number and Employer name on the Employee and Physician Statements.
- ☐ Employer is required to include the following (as applicable):
- Enrollment Form
 - Worker Compensation Report
 - W2
 - Job Description
 - Return-to-Work slip
 - Payroll Ledger
- ☐ Physician must completely fill out and sign the Physician Statement.
- ☐ Have all the physicians keep a copy of your signed authorization for their files.
- To file a Disability Claim or check on a status online go to www.sunlife.com/us.**
- Click on "Submit a Disability Claim"
 - OR Fax to: 781-304-5599

Employer's Statement

Group STD policy number
89588

1 General Information

Please print clearly.

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employer (parent company name) Oaktree Capital Management, L.P.		Employer phone number (213) 356-3267	
Employer street address 333 South Grand Avenue, 28th Floor	City Los Angeles	State CA	Zip code 90071
Name of employee (first, middle initial, last) Dana L Moolani		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Social Security number 595-01-8971
Employee street address 300 E 75th St. #325	City NY	State NY	Zip code 10021
Employee phone number Home 202-276-2191 Work 212-284-7891	Preferred form of contact <input checked="" type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Mail		Date of birth 05/11/1980

2 Employment and Claim Information

Attach Return-to-Work slip from physician.

Attach Worker's Compensation Report and Reward/Denial notice.

Is condition due to injury/sickness caused by patient's employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
Date hired 4/26/10	Start date of insurance	Date last worked before disability 3/18/16	Hours worked last day 8
Employee job title (Attach employee's formal job description) Vice President, Closed-end Fund Accounting			
List employee's major job duties			
How would you classify the employee's occupation? <input checked="" type="checkbox"/> Sedentary (1-10 lbs) <input type="checkbox"/> Light (11-20 lbs) <input type="checkbox"/> Medium (21-50 lbs) <input type="checkbox"/> Heavy (51+ lbs)			
Indicate days per week the employee regularly works? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7			
Indicate daily hours the employee regularly works. <input checked="" type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Other:			
Has employee terminated employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, termination date:			
Has employee returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, return date:			
If yes, did employee return: <input type="checkbox"/> Full-Time (full-capacity) <input type="checkbox"/> Full-Time (partial capacity) <input type="checkbox"/> Part-Time (attach payroll ledger)			
Has Worker's Compensation claim been filed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Name of Worker's Compensation carrier NA			Phone number NA

3 Salary and Benefits Information

If employee contributes to STD premium, attach a copy of employee enrollment form

How was the employee paid? (check one)

<input type="checkbox"/> Hourly \$ per hour:	<input checked="" type="checkbox"/> Salaried \$ per week:
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Other work related income:

Commissions \$	Bonuses \$	Overtime \$
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How does employee contribute toward the STD premium?

☐ PRE-tax ☐ POST-tax ☒ Employee does not contribute

If employee contributes, please provide percentage. _____ %

4 Information About Other Income

Indicate whether the employee is currently receiving, or entitled to receive, benefits from any of these sources.

Check all that apply.

Source of income	Payment Amount	Weekly or monthly?	Payment Coverage (M/D/Y)
<input type="checkbox"/> Sick pay	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Salary continuance	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> State Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Worker's Compensation	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Unemployment	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Social Security Disability	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:
<input type="checkbox"/> Other:	\$	<input type="checkbox"/> Wkly <input type="checkbox"/> Mthly	From: To:

5 Certification and Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Name of person completing this form Christine Mithiaru Sowers	E-mail address cmithiarusowers@oaktrecapital.com
Title Analyst	Phone number (213) 356-3267
Signature (original signature required) X	Date signed

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Employee's Statement

Group STD policy number
89588

1 General Information

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of employee (first, middle initial, last) <i>Dana L. Moolani</i>	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Social Security number <i>395-01-8971</i>	Date of birth (m/d/y) <i>5/11/80</i>
Employee street address <i>300 E 75th St #32J</i>	City <i>NY</i>	State <i>NY</i>	Zip code <i>10021</i>
Home phone: <i>202-276-2191</i>	Preferred form of contact:		
Cell phone: <i>202-276-2191</i>	<input type="checkbox"/> Home phone <input checked="" type="checkbox"/> Cell phone		
Work phone: <i>212-284-7891</i>	<input type="checkbox"/> Work phone <input type="checkbox"/> Mail		
Name of employer (parent company name) Oaktree Capital Management, L.P.			

2 Information About the Condition Causing Your Disability

Last day worked before disability <i>3/18/16</i>	Date first treated by Physician <i>8/25/15</i>	Date expected to return to work <input checked="" type="checkbox"/> FT <input type="checkbox"/> PT
Did you require Emergency Room care for your condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, Hospital name: Date: _____ Phone: _____		
Were you confined to a hospital for this condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, include the hospital name		Hospital phone
Date(s) of confinement: From: _____ To: _____		

Pregnancy - will provide actual delivery date and time in hospital

Select the appropriate type of condition, and provide details:

<input checked="" type="checkbox"/> Pregnancy
Expected due date: <i>8/26/16</i> Actual due date: <i>will provide</i>
Delivery type: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> C-Section
Complications:
<input type="checkbox"/> Work-related injury/sickness
Date of first symptom/injury:
Where occurred:
Cause of injury/sickness:
Do you intend to file for Workers Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the status: <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Appealed
<input type="checkbox"/> Sickness First date of symptom:
Type of sickness:
Have you experienced a symptom in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:

2 Information About the Condition Causing Your Disability continued

<input type="checkbox"/> Motor vehicle accident - complete only if applicable	
Date occurred:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Was a citation issued to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, type of citation:	
How injury occurred:	
Where injury occurred:	
Name of your car insurance carrier:	
Phone number:	
Are you receiving compensation from a car insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Date:	From: To:
<input type="checkbox"/> Other injury	
Date occurred:	Where occurred:
How occurred:	
Describe type of injury:	

3 Information About Other Income

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

<input checked="" type="checkbox"/> Sick pay/Salary continuance	<input type="checkbox"/> State Disability	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Other:		


4 Physician Information

Indicate physicians you are seeing or have seen for this condition.

Name of physician: <i>Dr. Jacques Montz</i>	Phone: <i>646-962-5662</i>
Specialty: <i>OB/GYN</i>	Fax: <i>646-962-0233</i>
Name of physician:	Phone:
Specialty:	Fax:

5 Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Employee's signature X 	Date signed <i>3/11/16</i>
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Sun Life Assurance Company of Canada

Short Term Disability Claim Packet



Attending Physician's Statement

Group STD policy number
89588

1 Information About the Patient

Patient is responsible for any costs associated with the completion of this form.

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Tel.: 800-247-6875
Fax: 781-304-5599
www.sunlife.com/us

Name of patient (first, middle initial, last) <i>Dana L. Moolani</i>	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Social Security number <i>595-01-8971</i>	Date of birth (m/d/y) <i>05/11/80</i>
Name of employer (parent company name) <i>Oaktree Capital Management, L.P.</i>			
Patient home street address <i>300 E 75th St #32J</i>	City <i>NY</i>	State <i>NY</i>	Zip code <i>10021</i>
Patient home phone number <i>202-276-2191</i>	Patient work phone number <i>212-284-7891</i>		

2 Physician Information

- Complete all sections – any missing information may result in a delay to your patient
- Print clearly
- Fax this form to 781-304-5599 or as instructed by patient

Name of attending physician (first, middle initial, last) <i>JACQUES MORITZ, MD</i>	Specialty <i>OB/GYN</i>	Tax ID# <i>131623978</i>
Street address <i>233 BROADWAY STE #2750</i>	City <i>NY</i>	State <i>NY</i>
Phone number <i>646-962-5662</i>	Fax number <i>646-962-0233</i>	Zip code <i>10279</i>

List other physicians treating for this condition *N/A*

Name of physician:	Phone:
Specialty:	Fax:
Name of physician:	Phone:
Specialty:	Fax:

3 Diagnosis and History

Your response is required and affects the patient's benefit. Failure to complete this information may cause the patient financial hardship due to lack of benefit payments.

Primary Diagnosis (include any complications) <i>PREGNANCY - AMP</i>	ICD-9 Code <i>009.523</i>
Secondary Diagnosis (if applicable)	ICD-9 Code
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date occurred:	
If pregnancy, provide the following: Expected delivery date: <i>3/26/16</i> Actual delivery date:	Delivery type: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section <i>ANTICIP. VAG.</i>
List any complications pre or post delivery that would extend this disability longer than a normal pregnancy. <i>UNKNOWN UNTIL POST DELIVERY</i>	
Is condition due to injury/sickness arising out of patient's employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

Describe objective or abnormal findings and date.

If you need more room, check here ☐ and attach a separate sheet.

<input type="checkbox"/> X-ray <input type="checkbox"/> EKG <input type="checkbox"/> MRI <input type="checkbox"/> PFT <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other data (e.g. Labs)
Date(s):
Findings:

4 Treatment Details

Start date of disability 3/21/2016	Date of first office visit 9/21/2015	Date of last office visit 3/11/2016	Date of next office visit 3/18/2016
Was Emergency Room care required for condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Name of hospital	Date	Phone number	

Check all that apply and describe type, frequency and treatment

<input type="checkbox"/> Surgery	<input type="checkbox"/> Medications prescribed	<input type="checkbox"/> Therapy	<input type="checkbox"/> Behavioral intervention	<input type="checkbox"/> Other
Date(s):				
Procedure/Treatment:				
Is patient: <input type="checkbox"/> Hospital confined	Date from:	Date to:		
<input type="checkbox"/> House confined	<input type="checkbox"/> Bed confined	<input type="checkbox"/> Ambulatory		
Hospital name:		Phone:		

5 Restrictions and Limitations

Describe what the patient can do .	From:
	To:
Describe what the patient should not do . NO HEAVY LIFTING	From: 3/21/2016
	To: 5/9/2016
Is patient capable of working with these restrictions/limitations? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<input type="checkbox"/> Full-Time: 8+ hours/day <input type="checkbox"/> Part-Time: _____ hours/day	

Indicate class of impairment - As defined in federal dictionary of occupation titles

Physical Impairment

<input type="checkbox"/> Class 1 - No limitation	<input type="checkbox"/> Class 4 - Moderate limitation
<input type="checkbox"/> Class 2 - Slight limitation	<input type="checkbox"/> Class 5 - Severe limitation
<input type="checkbox"/> Class 3 - Medium limitation	

Mental Impairment (if applicable)

Current DSM-IV-R diagnosis

<input type="checkbox"/> Class 1 - No limitation	Axis I:
<input type="checkbox"/> Class 2 - Slight limitation	Axis II:
<input type="checkbox"/> Class 3 - Moderate limitation	Axis III:
<input type="checkbox"/> Class 4 - Marked limitation	Axis IV:
<input type="checkbox"/> Class 5 - Severe limitation	Axis V:

Do you believe this patient is competent to endorse/direct the use of proceeds? ☐ Yes ☐ No

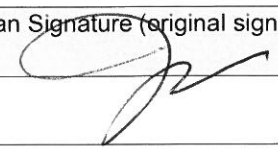
6 Return-to-Work

Indicate the specific date or recovery period for when the patient will recover sufficiently to perform duties.

• Return to patient's occupation full-time:	Date: 5/9/2016 -or-	(BASED ON EXPECTED DUE DATE 3/26/2016 9 VAG. DEL.)
<input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input type="checkbox"/> 5-6 wks <input checked="" type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks		
<input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____	<input type="checkbox"/> Never	
• Return to patient's occupation part-time:	Date: _____ -or-	
<input type="checkbox"/> 1-2 wks <input type="checkbox"/> 2-3 wks <input type="checkbox"/> 3-4 wks <input type="checkbox"/> 4-5 wks <input checked="" type="checkbox"/> 5-6 wks <input type="checkbox"/> 6-7 wks <input type="checkbox"/> 7-8 wks		
<input type="checkbox"/> 2 months or more <input type="checkbox"/> Other: _____	<input type="checkbox"/> Never	

7 Certification and Signature

I certify that the above statements are true and complete. I have read and understand the Fraud Warning in this packet.

Attending Physician Signature (original signature required) X 	Date 3/11/2016
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Sun Life Assurance Company of Canada



Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:

Sun Life Assurance
Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481

Fax: 781-304-5599

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy, or other medical or health care 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 Claims Department of Sun Life Assurance Company of Canada ("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, mental illness, and the use of alcohol, drugs, and tobacco, but shall 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/or (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 re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members, except as specifically allowed by this law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 Sun Life Financial, Group Short Term Disability Claims, SC4312, 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.

Print name of employee or personal representative of employee <i>Dana Moslan;</i>	Group policy number <i>89588</i>
If representative, description of your authority or relationship to employee	
Signature of employee or personal representative <i>X</i>	Date <i>3/11/16</i>