Sun Life Assurance Company of Canada

Group Enrollment form

Complete all sections of the Group Enrollment Form. Make sure you complete and sign the form during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

General information

Employer name	Policy number	Location	Date effective

Street address	City	State	Zip code

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Employee information

Employee's Full Legal Name (First, MI, Last) ☐ Male ☐ Female	Date of birth	Marital status	Social Security No.

Street address	City	State	Zip code

Current active employment type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary

You must elect or refuse insurance coverage below within 31 days of your date of eligibility by placing a check mark in the appropriate box(es). Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available and what your Maximum Guarantee Issue amount is. See "Evidence of Insurability" section for details.

Life and Disability coverage:

Employee Basic Life and AD&D ..... ☐ Elect ☐ Refuse
Dependent Basic Life and Dep AD&D ..... ☐ Elect ☐ Refuse
Employee Long Term Disability ..... ☐ Elect ☐ Refuse
Employee Short Term Disability ..... ☐ Elect ☐ Refuse

Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security No.	Date of birth	Check if elected Dep Life
Spouse / Partner			XXX-XX-		☐
Children			XXX-XX-		☐
			XXX-XX-		☐
			XXX-XX-		☐

Primary Beneficiary Designation

Basic Life and AD&D Insurance – On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Secondary Beneficiary Designation

Basic Life and AD&D Insurance– On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Evidence of Insurability

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage subject to Evidence of Insurability will not go into effect until Sun Life Assurance Company of Canada approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- I (and my dependents, if applicable) may be subject to medical questions if I am electing coverage outside of my eligibility period or if I decline coverage now and would like to sign up later. I understand that evidence of insurability must be acceptable to Sun Life Assurance Company of Canada, and I have read the "Evidence of Insurability" section**.**
- I have read the applicable Fraud Warning on page 4 of this enrollment form.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am verifying that the information I have provided is true and correct to the best of my knowledge and belief.

X _____ _____

Employee signature Today's date

To the employee: Make a copy of this form for your records before submitting it to your employer.

To the employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment form.