Sun Life Assurance Company of Canada
Group Enrollment Form

Employer Name	Policy Number	Current Active Employment Type ☐ Full Time ☐ Part Time	Occupation (Title)

Employee's Full Legal Name (First, MI, Last) ☐ Male ☐ Female	Date of Birth	Social Security Number	Marital Status

Street Address	City	State	Zip Code	Date of Employment/Rehire

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. Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available.

Basic Life coverage	☐ I Elect	☐ I Refuse
AD&D coverage	☐ I Elect	☐ I Refuse
Dependent Life coverage	☐ I Elect	☐ I Refuse
Short Term Disability coverage	☐ I Elect	☐ I Refuse
Long Term Disability coverage	☐ I Elect	☐ I Refuse

Optional Life coverage: If Optional Group Life Insurance coverage is available, use the Sun Life Assurance Company of Canada Optional Life Enrollment Form to enroll and calculate the cost of your coverage. For more information, please see your employer.

If your spouse and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number here. Attach additional pages if necessary.

	Full Legal Name (First, MI, Last)	Social Security Number	Date of Birth
Spouse			
Child			
Child			

Primary Beneficiary Designation (For Life Insurance only) — 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.

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

Secondary Beneficiary Designation (For Life Insurance only) — On the lines below, list the individual(s) who should receive 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. They are not paid if anyone listed above is alive when you die. Attach additional pages if needed.

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

* The total within each class (Primary and Secondary) must equal 100%

Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

Fraud Warning: Please read the fraud warning on the next page (reverse).

By signing below, you are verifying that the information you have provided is true and correct, and that you have read and understand the fraud warning on the reverse side.

X _____ _____

Employee Signature Today's Date

You must sign and date this form to become covered.

Employees: Make a copy of of this form for your records before submitting it to your employer.
Employers: This original enrollment form should remain at the employer's site. Family status, coverage or beneficiary changes should be recorded on another enrollment form.