

Sun Life Assurance Company of Canada

Group Enrollment Form

Instruction Page

Questions about this form?
 Call our Customer Service Center:
 (800) 247-6875

To all eligible employees: Beginning on the **next page**, complete all sections of the form to enroll in the Group Policy, to reinstate your coverage, or to refuse coverage. 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.

Do not send any copies of this form to Sun Life Assurance Company of Canada unless otherwise requested.

A Print out all three pages of the form and use this instruction page side by side when completing the form.

B Your employer will tell you which Sun Life Assurance Company of Canada benefits are available. Check off either "I elect" or "I refuse" for each benefit offered by Sun Life Assurance Company of Canada through your employer's plan.

C Optional Life Insurance is elected using another Sun Life Assurance Company of Canada form. See your employer for details.

D This form contains two places for you to name beneficiaries for your Life Insurance proceeds. Under the heading "Primary Beneficiary," you should list the person or persons who should receive proceeds in the event of your death. If you need additional space, attach another sheet to this enrollment form.

In the second box, under the heading "Secondary Beneficiary," you should list the person or persons who should receive the proceeds if every person listed in the box above is not living at the time of your death. If you list more than one person in either box, you will need to indicate the percentage of benefits each person will receive (the percentages in each box must total 100% exactly).

In this example, Greg and Sally Doe would receive the proceeds *only* if Mary Doe was not living when John Doe died.

If you do not designate a beneficiary, or if none of the beneficiaries you designated are living at the time of your death, payment will be made to your estate.

If you wish to make an absolute or collateral assignment, see your employer for the appropriate forms.

E Before you sign and date this form, please read the fraud warning on Page 3.

Sun Life Assurance Company of Canada

Group Enrollment Form

Group Policy #

12345

Company Name ABC Manufacturing		Employee Full Legal Name (Last, First, M.I.) Doe, John A.		Date of Birth 11/19/55	Social Security No. 123-45-678X
Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status Married	Date of Employment/Status 3/1/98	Occupation (Title) Manager	Current Actual Employment Type <input checked="" type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Basic Monthly Earnings \$ 2,500

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. All of the insurance coverage listed below may not be available to you; check with your employer.

Your employer will tell you which benefits are available: Basic Life coverage <input checked="" type="checkbox"/> I Elect <input type="checkbox"/> I Refuse AD&D coverage <input checked="" type="checkbox"/> I Elect <input type="checkbox"/> I Refuse Dependent Life coverage <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse Short Term Disability coverage <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse Long Term Disability coverage <input checked="" type="checkbox"/> I Elect <input type="checkbox"/> I Refuse	<div style="border: 1px solid black; padding: 5px;"> <p style="margin: 0;">Optional Life coverage</p> <p style="margin: 0; font-size: small;">If Optional Life coverage is available, then use this form to elect or refuse Optional Life coverage. This form is also used to designate beneficiaries for Optional Life coverage. See your employer for details.</p> </div>
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If your spouse and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number to the right of this box. Attach additional pages if necessary.	Full legal Name (Last, First, M.I.)	Date of Birth	Social Security No.
	Doe, Mary L.	03/10/84	123-45-678X
	Doe, Greg B.	01/05/80	123-45-687X
	Doe, Sally P.	07/22/91	123-45-627X

Primary Beneficiary Designation (For Life Insurance Only) — See instructions on cover page. On the lines directly below, list the individual(s) that you want to receive proceeds in the event of your death. You may specify as many individuals as you would like, but the total proceeds must equal 100% of your primary beneficiary. Attach additional pages if necessary.

Primary Beneficiary (Last, First, M.I.)	Relationship to employee	Percent share of proceeds (must equal 100%)
Doe, Mary L.	Wife	100%
\$ - 100%		
Secondary Beneficiary Designation — 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.		
Primary Beneficiary (Last, First, M.I.)	Relationship to employee	Percent share of proceeds (must equal 100%)
Doe, Greg B.	Son	50%
Doe, Sally P.	Daughter	50%
\$ - 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 Page 3.

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

John Doe

Employee Signature

3/1/98

Employee Date

You must sign and date this form to become covered.

Employees: Make a copy of both sides 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.

GR/645
SLPC 3830 5/01

Sun Life Assurance Company of Canada

Group Enrollment Form

Company Name		Employee's Full Legal Name (First, MI, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security No.
Policy No.	Marital Status	Date of Employment/Rehire	Occupation (Title)	Current Active Employment Type <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Basic Monthly Earnings \$

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 Life coverage is available, then use the Sun Life Assurance Company of Canada Optional Life Enrollment Form to elect or refuse Optional Life coverage. This form is also used to designate beneficiaries for Optional Life 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 to the right of this box. Attach additional pages if necessary.	Full Legal Name (First, MI, Last)	Date of Birth	Social Security No.

Primary Beneficiary Designation (For Life Insurance ONLY) – See instructions on cover page. On the lines directly below, list the individual(s) that you want to receive proceeds in the event of your death. You may specify as many individuals as you would like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary.

Primary Beneficiary(ies): (Last, First, M.I.)	Relationship to employee	Percent share of proceeds (must equal 100%)
		%
		%
		% =100%

Secondary Beneficiary Designation — 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.

Secondary Beneficiary(ies): (Last, First, M.I.)	Relationship to employee	Percent share of proceeds (must equal 100%)
		%
		%
		% =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 [Page 3](#).

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.

Employee Signature _____	Today's Date _____
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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.

Please read the fraud warning below before signing the Enrollment Form.

State law requires that we notify you of the following:

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD WARNING - FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FRAUD WARNING - FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD WARNING - FOR RESIDENTS OF LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING - FOR RESIDENTS OF MARYLAND: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

FRAUD WARNING - FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD WARNING - FOR RESIDENTS OF VIRGINIA: 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.