

Sun Life Assurance Company of Canada

Group Enrollment Form – Basic Life and AD&D Only



| | | | |
|--|---------------|--|--------------------|
| Employer Name | Policy Number | Current Active Employment Type <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | Occupation (Title) |
| Employee's Full Legal Name (First, MI, Last) <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | Social Security Number | Marital Status |
| Street Address | City | State | Zip Code |
| | | Date of Employment / Rehire | |

GROUP INSURANCE COVERAGE

Your coverage includes **Basic Life** and **Accidental Death and Dismemberment (AD&D)** insurance.
These benefits are completely paid by 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.

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.

For Employer Use Only

| | | |
|----------|--------------------------|-------------------------------|
| Location | Plan (Group of Benefits) | Social Security No./Member ID |
|----------|--------------------------|-------------------------------|

Please provide the employee's earnings amount below. Indicate whether earnings amount is annual pay, or some other pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

| | | | | |
|----------------|-----------------------------------|---------------------------------------|--|---------------------------------|
| Earnings \$ | <input type="checkbox"/> Annually | <input type="checkbox"/> Semi-monthly | <input type="checkbox"/> Weekly | <input type="checkbox"/> Hourly |
| | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bi-Weekly | Number of hours worked per week: _____ | |

Fraud Warnings: 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 Oregon, Virginia and Washington: 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.