

Sun Life Insurance and Annuity Company of New York

Policyholder Information



Thank you for choosing Sun Life Insurance and Annuity Company of New York (“Sun Life (N.Y.)”), a member of the Sun Life Financial group of companies. We appreciate your assistance in providing the following information to help us set up your policy and booklets. Please return this form with your signed application.

1 Plan Sponsor Information

Internal use only:
Group Office

Account Manager

Phone

Full Legal Name of Policyholder		Policy number (if available)	
Street address			
City	State	Zip code	

2 Contact Information and *CustomerLink* Authorization

Please provide name, address, phone and email address for your **Primary** and **Secondary** Benefits Administrators. Then, assign *CustomerLink* access and check-off responsibilities/roles for each person.

New users will receive a registration email containing their temporary user name and password. Follow the instructions in the email to complete the registration process.

Check here if you do not have internet access.

About *CustomerLink*

CustomerLink is our secure online service center for Group Policyholders. You can designate yourself, or other authorized employees from your organization, as *CustomerLink* users. Choose each user’s access level below:

Level I: Level I users must be employees of your organization who are authorized to view and change employee salary and benefit information (i.e. your Human Resources and/or Benefits manager(s)). Please carefully consider who you want to designate as a **Level I** user.

Level II: Level II users should be employees of your organization who administer your group benefit plan but are not authorized to view and change employee salary and benefit information.

Primary Benefits Administrator

Name of Primary Benefits Administrator		Title	
Street address (if different)		City	State Zip Code
Phone number & ext.	Fax number	Email address	
CustomerLink access (check one)			Responsibilities/Roles (check all that apply)
Level I <input type="checkbox"/>	Level II <input type="checkbox"/>	Non-user <input type="checkbox"/>	Addressee for correspondence <input type="checkbox"/> Claim filing <input type="checkbox"/> Premium/Billing <input type="checkbox"/> Contract Revisions/Changes <input type="checkbox"/>

Secondary Benefits Administrator

Name of Secondary Benefits Administrator		Title	
Street address (if different)		City	State Zip Code
Phone number & ext.	Fax number	Email address	
CustomerLink access (check one)			Responsibilities/Roles (check all that apply)
Level I <input type="checkbox"/>	Level II <input type="checkbox"/>	Non-user <input type="checkbox"/>	Addressee for correspondence <input type="checkbox"/> Claim filing <input type="checkbox"/> Premium/Billing <input type="checkbox"/> Contract Revisions/Changes <input type="checkbox"/>

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3 Additional Locations (Optional)

Complete this section ONLY if you have people in separate locations requiring separate premium payment, *CustomerLink* access, correspondence, reporting, etc.

If you need more room, please attach a separate sheet identifying locations and contact names.

Location 002

Check one: Subsidiary/Affiliate Division

Does this location require separate premium payment:..... Yes No

Name of Subsidiary/Division			No. of employees at location		
Name of Contact Person			Title		
Street address			City	State	Zip Code
Phone number & ext.		Fax number		Email address	
CustomerLink access (check one)			Responsibilities/Roles (check all that apply)		
Level I <input type="checkbox"/>	Level II <input type="checkbox"/>	Non-user <input type="checkbox"/>		Correspondence <input type="checkbox"/>	Claim filing <input type="checkbox"/>
			Premium/Billing <input type="checkbox"/>		

Location 003

Check one: Subsidiary/Affiliate Division

Does this location require separate premium payment:..... Yes No

Name of Subsidiary/Division			No. of employees at location		
Name of Contact Person			Title		
Street address			City	State	Zip Code
Phone number & ext.		Fax number		Email address	
CustomerLink access (check one)			Responsibilities/Roles (check all that apply)		
Level I <input type="checkbox"/>	Level II <input type="checkbox"/>	Non-user <input type="checkbox"/>		Correspondence <input type="checkbox"/>	Claim filing <input type="checkbox"/>
			Premium/Billing <input type="checkbox"/>		

4 Third Party Administrator (If Applicable)

Complete this section only if your premium will be administered by a Third Party Administrator (TPA) or Administrative Service Only (ASO) provider.

Will your Premium be paid by a TPA/ASO provider Yes No

If "yes," please complete a TPA Agreement and return it to your Sales Representative.

Name of TPA/ASO Provider		Name of TPA/ASO Provider Contact Person			
Phone number & ext.		Email address			
Street address		City	State	Zip Code	

5 Leave of Absence, Layoff and Re-Hire

How long will coverage be maintained during an approved Leave of Absence?

1 month Other (please specify)

How long will coverage be maintained during an approved Layoff?

1 month Other (please specify)

If an employee is **Re-Hired**, will his/her previous benefits be reinstated with no new waiting period?

Yes, within 6 months (standard) Yes (specify other rehire period) _____ No

If you checked *other* above, please include a description of your Leave, Layoff and/or Re-Hire policy:

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6 Employee Contributions

If employees contribute to the cost of any of the benefits listed here, please indicate the percentage and type of contribution.

	Employee Contribution	Employer Contribution
Group Life and AD&D	_____ % <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	_____ %
Short Term Disability	_____ % <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	_____ %
Long Term Disability	_____ % <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	_____ %

Are your Sun Life (N.Y.) benefits funded through a Section 125 Plan on a Pre-Tax basis? Yes No

7 Earnings Definition

Please select the appropriate Earnings Definition for your plan. Specify by class if using more than one.

Please Note: The Earnings Definition for employees affects how Premiums are paid and how Claim Benefits are calculated.

	Class	Averaging Schedule
<input type="checkbox"/> Standard Earnings (Does not include commissions, bonuses, overtime or extra compensation)		N/A
<input type="checkbox"/> Standard + Commissions (Does not include bonuses, overtime or extra compensation)		<input type="checkbox"/> 24-month <input type="checkbox"/> 36-month
<input type="checkbox"/> Standard + Bonuses (Does not include commissions, overtime or extra compensation)		<input type="checkbox"/> 24-month <input type="checkbox"/> 36-month
<input type="checkbox"/> Standard + Commissions + Bonuses (Does not include overtime or extra compensation)		<input type="checkbox"/> 24-month <input type="checkbox"/> 36-month
<input type="checkbox"/> W-2 (Includes wages, tips, commissions, bonuses, extra compensation but not pre-tax contributions)		N/A
<input type="checkbox"/> K-1 Earnings (applicable for partners)		<input type="checkbox"/> 24-month <input type="checkbox"/> 36-month

8 Life Insurance Age Reduction

For Life Insurance, what **Age Reductions** apply to your policy? Check one below. Rates are based on the **Standard** Age Reductions as listed in the proposal.

	At age:	Reduce to:	At age:	Reduce to:	At age:	Reduce to:
<input type="checkbox"/> Age Reduction Type A	N/A	N/A	70	67%	75	50%
<input type="checkbox"/> Age Reduction Type B	65	65%	70	50%	N/A	N/A
<input type="checkbox"/> Age Reduction Type C	65	67%	70	50%	N/A	N/A
<input type="checkbox"/> Age Reduction Type D	N/A	N/A	70	50%	N/A	N/A
<input type="checkbox"/> Other						

9 Short Term Disability Plan Options

- What will the STD benefit calculation be based upon (check one)?
 Standard 7-day week (Monday through Sunday) 5-day week (Monday through Friday)
- Where should STD checks be mailed (check one)?
 Employee's home address Employer's address
- Where should STD Explanation of Benefits (EOBs) be mailed (check one)?
 Primary Benefits Contact listed in section 2 of this form Contacts at each location (listed in sections 2 and 3) from which claims originated
- Where should monthly STD reports be sent (check one)?
 Primary Benefits Contact listed in section 2 of this form Contacts at each location (listed in sections 2 and 3) with claim activity

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10 Other Plan Options

The following questions affect contract wording in your group policy and booklets.

1. How should the following changes be handled? (check one for each type of change below)

Type of change	Effective immediately on the date of change	Other (Please specify at right)	
■ Salary/earnings changes:	<input type="checkbox"/>	<input type="checkbox"/>	
■ Changes in age:	<input type="checkbox"/>	<input type="checkbox"/>	
■ Changes in class:	<input type="checkbox"/>	<input type="checkbox"/>	

2. Do you require employees to enroll in another plan to be eligible for Sun Life (N.Y.) benefits?

No Yes If Yes, please describe enrollment participation requirements:

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11 Booklets

Questions about booklets? Please contact your local Account Manager.

Upon approval of your plan, Sun Life (N.Y.) will work with you to develop the text and layout of your booklet certificates. We then supply you with the final document so that you can distribute it to your employees. We can provide the booklet document to you in two ways: in a **PDF file** or **printed**.

- **PDF file:** Your booklets will be available in Adobe Acrobat (PDF) format on *CustomerLink*, allowing you to print copies as needed, email to employees and post on your internal network/intranet.
- **Printed booklets:** In addition to the PDF document(s) on *CustomerLink*, we can provide you with an initial supply of printed booklets. Specify classes, quantity and cover style below. Please allow 4–6 weeks for completion of your booklet document (longer during peak times). For reorders, use form XNYGR/1238 or call **1-800-247-6875**. A fee for printing and shipping of reorders may apply.

To verify benefits, please provide a copy of your prior carrier's employee booklet or Summary Plan Description. Provide your prior carrier's name and years of service here:

Name of booklet (employee class)	Quantity	Cover style (black lettering on one of the following covers:)
		<input type="checkbox"/> White <input type="checkbox"/> Gray <input type="checkbox"/> Ivory <input type="checkbox"/> Green <input type="checkbox"/> Blue
		<input type="checkbox"/> White <input type="checkbox"/> Gray <input type="checkbox"/> Ivory <input type="checkbox"/> Green <input type="checkbox"/> Blue
		<input type="checkbox"/> White <input type="checkbox"/> Gray <input type="checkbox"/> Ivory <input type="checkbox"/> Green <input type="checkbox"/> Blue
Name of prior carrier		Number of years with prior carrier

12 ERISA Information (Not required for public entities or groups under 100 lives)

Employer Identification Number (EIN)	Fiscal Year End	Assigned Welfare Benefit Plan Number	
		<u>5</u>	
Company/Agent Name for Legal Process			
Street Address	City	State	Zip code

13 Authorization and Signature

Please return this form, the group insurance application, and all additional required documentation to your Sales Representative.

Note: Employees who are Pilots, Board of Directors, Foreign Nationals, and employees residing outside the United States, will not be covered unless approved by Underwriting.

Authorization: On behalf of the Policyholder, I authorize the employees named in Sections 2 and 3 to have the specified access to *CustomerLink* with respect to the Group Policy named herein and request that a user name and password be assigned to them to allow for such access.

Primary Benefits Administrator (or Authorized Representative)	Title
Signature of Primary Benefit Admin/Authorized Representative X	Today's date

Thank You!