

Sun Life Insurance and Annuity Company of New York Group Enrollment Form



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|--|---------------|--|--------------------|---------------------------|----------------|
| 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 | |

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
 Long Term Disability coverage I Elect I Refuse

Optional Life coverage: If Optional Group Life Insurance coverage is available, use the Sun Life Insurance and Annuity Company of New York 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.

For Employer Use Only

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

Provide the employee's earnings amount below. Most employers should use the "All Coverages" box only. However, if your group policy requires that you calculate separate earnings amounts by coverage, please enter those amounts in the second set of boxes.

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.

| | | | | |
|-----------------------------|-----------------------------------|---------------------------------------|--|---------------------------------|
| All Coverage 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: _____ | |

| | | | | |
|---------------------|-----------------------------------|---------------------------------------|--|---------------------------------|
| Life 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: _____ | |

| | | | | |
|--------------------|-----------------------------------|---------------------------------------|--|---------------------------------|
| LTD 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 Warning: Please read the fraud warning below before signing the Enrollment Form. State law requires that we notify you of the following:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.