Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
Attn: Group Eligibility - WIN 407
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

ENROLLMENT REQUEST

☐ **Add** ☐ **Change** ☐ **Termination** ☐ **Correction**

Date: _____ **Reason:** _____

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group

4. Name of Employer

5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.) | 7. Social Security Number

8. Employee's Address (Number, Street, City, State, ZIP Code) | 9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female

11. Date of Birth (Mo., Day, Yr.)

12. Marital Status ☐ Single ☐ Married

13. My employment is covered under Union Collective Bargaining ☐ Yes

14. Hours worked weekly for this employer (Excluding Overtime)_____ ☐ Active ☐ Retired

15. Date Employed (Mo., Day, Yr.) ☐ Full-Time ___/___/___ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___

16. Basic Earnings $ _____ ☐ Hourly _____ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually

17. Employee's Occupation (Title)

NOTE: If you refuse Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) does not imply liability for SLHIC (U.S.) for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Dental ☐ I Elect ☐ I Refuse

If you have refused Dental, is it because you have other Group Coverage? ☐ Yes ☐ No

Dependent Dental ☐ I Elect ☐ I Refuse

If you have refused Dental for your dependents, is it because they have other Group Coverage? ☐ Yes ☐ No

Please complete this *entire* section if you are selecting Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /
						/ /

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: _____

School Name and Address: _____

Course of Study: _____ Semester: _____ Anticipated Date of Graduation (month/year): _____

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date	25. Signature

WARNING

Disability income benefits may be reduced by other sources of income. Read your certificate carefully.

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:
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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and (in North Carolina, "may subject") subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN 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."

IN LOUISIANA: "Any person 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."

IN 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."

IN NEW YORK: "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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. THIS NOTICE DOES NOT APPLY TO AN APPLICATION FOR LIFE INSURANCE."

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.

In Georgia, any person who signs this Enrollment Form acknowledges notification of the following:

1. You are entitled to a list of providers participating in our PPO network. Provider Directories are available by contacting our Group Policyholder Services Department at 800-451-2513 or by viewing our website at https://ebg.sunlife.com.
2. You are entitled to receive treatment from a provider of your choosing. You will receive a higher level of benefits for medical services when choosing a PPO physician or hospital.
3. There are no limited utilization incentive plans for providers of medical services. The provider is not given an incentive or bonus that encourages withholding services or influences referral to specialists.

You will be provided with a Disclosure form after the effective date of your Group Policy. This Disclosure will provide details of the above.