Sun Life Insurance and Annuity Company of New York
Application for Group Insurance

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

Applicant Organization

Please PRINT clearly.

Legal Name		
Main Address		
City	State	Zip code
Nature of Business		

Subsidiaries or Affiliates to be Included

Legal Name
Address
Nature of Business

Legal Name
Address
Nature of Business

☐ If you need more space, check here and attach a separate page.

Eligible Employees

Eligible Classes	
Number of Eligible Employees on the Effective Date	Minimum Work Week hrs.

Are Retirees eligible? ..... ☐ Yes ☐ No

Waiting Period

Specify days or months required for new employees to be eligible for benefits.

Current employees who have not satisfied the waiting period will receive credit for past service to complete the waiting period.

Benefits Requested

Benefit	% of Premium Paid by Employer	Benefit	% of Premium Paid by Employer
☐ **Basic Life**	%	☐ **Basic AD&D**	%
☐ **Optional Life**	%	☐ **Optional AD&D**	%
☐ **Dependent Life**	%	☐ **Long Term Disability**	%

Authorization

Effective Date (m/d/y)	Amount Paid with this Application $

Subject to approval by Sun Life Insurance and Annuity Company of New York, we will issue a Group Policy with insurance coverage to become effective on the Effective Date. The Applicant agrees to provide Sun Life Insurance and Annuity Company of New York with a current census, as of the Effective Date, on all eligible employees and all data on employees not actively at work. This information is required no sooner than the Effective Date and no later than 15 days after the Effective Date. Employees not actively at work on the Effective Date will only be insured as required by law or as approved in writing by Sun Life Insurance and Annuity Company of New York. This Application will be attached to and is made a part of the Group Policy.

Countersigned by (Licensed Resident Agent) X
Name and Address of Agent / Broker Firm

Signature of Authorized Representative of Applicant Organization X
Name and Title
Place and Date of Signing

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an accident and health 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.

Sun Life Insurance and Annuity Company of New York

Policyholder Contact Information

We appreciate your assistance in providing complete contact information for your account. For new policies, please complete all sections of this form and return with your signed application. To change contact information for an existing policy, use sections 1-2.

1 Policyholder Information

Please return this form and all required documentation to the Sun Life Financial Group Sales Office.

Full legal name of group policyholder (to appear on contract/policy documents)		Policy number
Address line 1 (If different than Master Application)		
Address line 2 (optional)		
City	State	Zip code

2 Benefits Representatives and Internet Access

Provide name, address, phone and email address of the Primary Benefits Representative. The Primary Representative, and any other contact people you add to this form, will automatically be Head Administrators on CustomerLink, our web site for benefits managers.

Email address is required for internet access.

A. Primary Benefits Representative (HR/Benefits contact person who is an employee of the policyholder)

Name of **Primary** Benefits Representative	Title	Phone number and ext.
Street address (if different)		
City	State / Zip Code	Fax number
Internet Access:		
Email address of Primary Benefits Representative	☒ Head CustomerLink Administrator * (Default to ALL permissions)	

B. Additional Representatives

Name of Representative	Email address	Head CustomerLink Administrator *
Name of Representative	Email address	☒
Name of Representative	Email address	☒

* **Representatives added to this form must be Head CustomerLink Administrators –** After registering online, Head Administrators may add additional users to the CustomerLink web site. CustomerLink offers additional configuration options that you can set for each of your users (i.e. turn on/off access to areas of the site, email alerts, etc.). Please see the Manage Users section of the site for more information.

Head Administrators automatically have access to all billing locations (if any) and all areas of the site:

- **Membership & Billing** – For online billing customers only
- **Premium Payment** – Available to self-billing customers only as a substitute for online billing
- **Claims** – Available to customers with LTD, STD or SunAdvisor
- **Evidence of Insurability**
- **Policies and Booklets**

Please Note – Online Billing Required Data: All Online Membership & Billing customers are required to submit a detailed member data listing for initial setup. We will provide a data template for you to use to submit your member information (i.e. name, date of birth, earnings, class, insurance elections, etc.).

Continued on next page

3 Additional Contacts (Optional)

Will your plan have multiple billing groups/locations? ..... ☐ Yes ☐ No
If Yes, please specify contact information for additional billing groups/locations below.

To add more locations, check here ☐ and attach a separate page.

If Benefit Reps listed here will be Head CustomerLink Administrators (access to all areas and locations), please provide their name and email address in Section 2 of this form.

Additional Billing Group/Location 1

Name of location (if applicable)	No. of employees at location:	This location is: ☐ Subsidiary/affiliate ☐ Division	
Name of Benefits Representative at this location	Title	Phone number and ext.	
Street address (if different)	City	State	Zip code

Additional Billing Group/Location 2

Name of location (if applicable)	No. of employees at location:	This location is: ☐ Subsidiary/affiliate ☐ Division	
Name of Benefits Representative at this location	Title	Phone number and ext.	
Street address (if different)	City	State	Zip code

4 Member Administration & Billing

Our preferred method of administration is Online Membership & Billing. Please see the chart below to learn more about the advantages of Online Membership & Billing. Select one option below.

Features:	Online Membership & Billing	List Bill	Self-Admin
Employer required to submit a detailed member data file in Excel format for initial setup	ü	ü	
Fast, easy entry of member changes (adds, updates, etc.)	ü		
Real-time confirmation of member changes	ü		
Required to fax or mail enrollment forms		ü	
Convenience of 24x7 access to member data	ü		
Monthly billing reminder email	ü		
Generate reports online, including coverage summaries for employees	ü		
Ability to restrict access by billing groups/locations	ü		
Available to employers with 10 to 300 employees	ü	ü	ü
Available to employers with 300+ employees	ü		ü

Select one:

☐ **Online Membership & Billing** ☐ List Bill ☐ Self-Administration Bill

5 Third Party Administrator Contact Information (Optional)

Complete this section only if you are using a TPA for premium, claims, etc.

Name of Third Party Administrator (TPA) **Firm**		Email address	
Name of **Contact Person** at TPA Firm	Title	Phone number	
Street Address of Firm	City	State	Zip code

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6 Administrative Options

General Option:

A. Which party will submit claims to Sun Life Financial? (check one)
☐ Primary Rep only ☐ Primary and additional Reps ☐ TPA (please complete Section 3 above)

Disability Plan Options: (for LTD, STD and SunAdvisor® customers only)

B. Where should STD claims checks be mailed? (check one)
☐ **Employee's** home address ☐ **Employer**

C. Where will LTD and STD monthly claims reports and Explanation of Benefits (EOBs) be sent?
☐ To one recipient only (e.g. Primary Rep) ☐ To multiple recipients
If multiple, your Account Manager will contact you to collect recipient information.

D. If any of these benefits are employee-paid, are premiums paid on a pre- or post-tax basis?
STD: ☐ Pre-tax ☐ Post-tax **SunAdvisor:** ☐ Pre-tax ☐ Post-tax **LTD:** ☐ Pre-tax ☐ Post-tax

Note – Service Guarantee (STD/SunAdvisor Only): Any service guarantee for Short Term Disability and/or SunAdvisor claims will not become effective until we receive and approve all documents, data and forms required for sold-case setup.

7 Employee eBooklet Documents

Your employee **eBooklet** document(s) will be available on CustomerLink in Adobe® Acrobat® format, making it easy for you to print copies, email them to employees and post them on your intranet. Please specify the title(s) that should appear on your eBooklet(s):

Title of eBooklet 1:

If you need more room, check here ☐ and attach a separate sheet.

Do you want eBooklets split by class/location? ☐ Yes ☐ No
If Yes, complete the boxes below (or use a separate sheet)

Title of eBooklet 2:

Title of eBooklet 3:

Example: *Group Life and Disability Benefits for Full Time Employees of XYZ Company*

8 Standard Policy Provisions

The following are brief descriptions of certain provisions which, unless otherwise noted in your proposal, will be standardly included in your group policy. If your plan is in any way not compatible with these provisions, you must inform your Group Sales Representative or Account Manager as soon as possible.

- **Leave of Absence:** Coverage will be maintained for up to one month during an approved leave of absence or layoff, and up to three months during a vacation.
- **Rehire:** If an employee is rehired within six months of termination, his/her benefits will be reinstated with no waiting period.
- **Changes in Insurance:** Benefit changes due to changes in salary/earnings, schedule of benefits, age or class take effect immediately on the date of change and should be reflected in subsequent monthly premium payments.

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9 ERISA Information – Not required for public entities

Does ERISA plan information need to be included in your eBooklet document(s)? ..... ☐ Yes ☐ No
If Yes, please provide all of the following required information:

Employer Identification Number (EIN)	ERISA Plan Number	Plan Year End
Agent/Service for Legal Processes		

10 Authorization and Signature

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Authorization: On behalf of the Policyholder, I authorize the employees named in Section 2 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 Representative or Authorized Representative (please print)	Title
Signature of Primary Benefits or Authorized Representative X	Today's date