Sun Life Financial
Employee Benefits Group

Sun Life and Health Insurance Company (U.S.)*
175 Addison Road, Win-300
Windsor, CT 06095

NEW BUSINESS ENROLLMENT FORM

Requested Effective Date ☐ New Submission ☐ Addition of Coverage: Account No.:

Employer Information

Employer's Legal Name	Telephone Number (Include Area Code)	Fax Number
Employer's Business Address (No., Street, City, State, Zip) (NOTE: There are no supply deliveries to a P.O. Address)		County

Type of Legal Entity

☒ Corporation ☐ Sole Proprietorship ☐ Partnership ☐ LLC/LLP ☐ Other (Specify) _____

Administrative Contact/Title	Admin Contact E-mail Address	Employer's Tax ID Number
Nature of Business	SIC Code	Years in Business

Subsidiaries/Alternate Locations

Indicate subsidiaries or other locations, affiliates to be covered: (Attach listing if additional space is required)

Name	Address (No., Street, City, State, Zip)	Tax ID	SIC Code	Nature of Business

<u>Non-Voluntary</u> Administration (Accounts with less than 10 lives will have an Administrative Billing Fee assessed. This is not applicable to fully insured medical coverage.)

Frequency of Bill (check one): ☐ Monthly ☐ Quarterly based on effective date ☐ Quarterly based on calendar quarters

Enrollment Method (check one): ☐ Enrollment Form ☐ Web Enrollment

Bill Type (check one): ☐ List ☐ Modified List Bill (100+ Lives) ☐ Self-Accounting Bill (SA) (300+ Lives)

Please Select One Bill Format:

☐ Single Bill (Alphabetical listing)
☐ Divisional Bill (Single bill itemized by location/division. Provide census list with employee and location/division names)
☐ Multiple Billing (Separate bills by location/division/coverage. Provide census list w/ location name, address, phone, fax, and contact and e-mail address)

<u>Voluntary</u> Administration

Frequency of Bill: ☐ Monthly **Bill Type**: ☐ List

Please Select One Bill Format:

☐ Single Bill (Alphabetical listing)
☐ Divisional Bill (Single bill itemized by location/division. Provide census list with employee and location/division names)
  ☐ Send copies of bill to separate addresses (provide addresses)
  _____
☐ Multiple Billing (Separate bills by location/division/coverage)
  ☐ Mailed to a single location (Provide census list w/ location name, address and contact)
  _____

Pay Frequency: (If multiple pay frequencies are selected, please provide description for each pay frequency)

☐ **12 (monthly)** Start Date:_____ ☐ **24 (semin-monthly)** Start Date:_____
☐ **26 (bi-weekly)** Start Date:_____ ☐ **52 (weekly)** Start Date:_____ ☐ **Other** Start Date:_____

*Formerly known as Genworth Life and Health Insurance Company.
Sun Life and Health Insurance Company (U.S.) is a member of the Sun Life Financial group of companies.

Waiting Period (if differs by coverage, specify below)

From Date of Hire:

☐ None (Not available for Voluntary coverages)*

☐ First of the month following date of hire

☐ First of month coinciding with or following days or _____ months

☐ Other (specify) _____

☐ Separate waiting period for add classes (Please explain) _____

*Voluntary coverages require a first of the month waiting period

Example: If first of the month coinciding with or following 30 days is checked, an employee hired on March 14th will not be eligible until May 1st even if the plan's effective date with Sun Life and Health Insurance Company (U.S.) is April 1st.

Mailing Instructions

Please mail Administrative Guide to (check one): ☐ Employer ☐ other:

Please mail STD Explanation of Benefits (EOB) and Claim Checks to: ☐ Employee ☐ Employer

Certificates

Certificates will be available on our website at http://ebg.sunlife.com within two weeks of receiving your initial billing statement

☐ Include Summary Plan description information along with certificate (Complete ERISA section)

Employer name to be used on Employee certificates (if different than above) _____

Workers Compensation

Are employees covered by a plan providing Workers' Compensation (check one): ☐ Yes ☐ No

If "yes", indicate carrier name:

Employee Contributions

Total Number of Employees employed:

Group Life/AD&D

Number of employees not eligible for coverage: _____

Reason for not being eligible: # Part-time _____ Other (Please explain) _____

	Do Employees contribute to the cost of coverage	Number of Eligible Employees/Dependents	Number of Participating Employees/Dependents
☐ Employee Life/AD&D	☐ No ☐ Yes	_____	_____
☐ Dependent Life/AD&D	☐ No ☐ Yes	_____	_____

Voluntary Life/AD&D

Number of employees not eligible for coverage: _____

Reason for not being eligible: # Part-time _____ Other (Please explain) _____

	Do Employees contribute to the cost of coverage	Number of Eligible Employees/Dependents	Number of Participating Employees/Dependents
☐ Employee Life/AD&D	☐ No ☐ Yes		_____
☐ Spouse Life/AD&D	☐ No ☐ Yes	_____	_____
☐ Child Life/AD&D	☐ No ☐ Yes	_____	_____

Dental ☐ Traditional ☐ Voluntary ☐ Administrative Services Only

Number of employees eligible but covered elsewhere: _____ Number of Employees not eligible for coverage: _____

Reason for not being eligible: # part time _____ Other (Please explain) _____

	Do Employees contribute to the cost of coverage?	Number of Eligible Employees	Number of Participating Employees
☐ Employee Coverage	☐ No ☐ Yes _____% or $_____	_____	_____
☐ Dependent Coverage	☐ No ☐ Yes _____% or $_____	_____	_____

Long Term Disability ☐ Traditional ☐ Voluntary

Number of Employees not eligible for coverage: _____

Reason for not being eligible: # part time _____ Other (Please explain) _____

	Do Employees contribute to the cost by payroll deduction?	Number of Eligible Employees	Number of Participating Employees
Employee Coverage	☐ No ☐ Yes _____% or $_____	_____	_____

If "yes", then ☐ Pre-Tax or ☐ Post-Tax

Short Term Disability ☐ Traditional ☐ Voluntary

Number of Employees not eligible for coverage: _____

Reason for not being eligible: # part time _____ Other (Please explain) _____

	Do Employees contribute to the cost by payroll deduction?	Number of Eligible Employees	Number of Participating Employees
Employee Coverage	☐ No ☐ Yes _____% or $_____	_____	_____

If "yes", then ☐ Pre-Tax or ☐ Post-Tax

Fully Insured Medical

Number of employees eligible but covered elsewhere: _____ Number of Employees not eligible for coverage: _____

Reason for not being eligible: # part time _____ Other (Please explain) _____

	Do Employees contribute to the cost by payroll deduction?	Number of Eligible Employees	Number of Participating Employees
Employee Coverage	☐ No ☐ Yes _____% or $_____	_____	_____
Dependent Coverage	☐ No ☐ Yes _____% or $_____	_____	_____

Number of dependents covered under other plan _____

Stop Loss

Number of employees eligible but covered elsewhere: _____ Number of Employees not eligible for coverage: _____

Reason for not being eligible: # part time _____ Other (Please explain) _____

	Do Employees contribute to the cost by payroll deduction?	Number of Eligible Employees	Number of Participating Employees
Employee Coverage	☐ No ☐ Yes _____% or $_____	_____	_____
Dependent Coverage	☐ No ☐ Yes _____% or $_____	_____	_____

Number of dependents covered under other plan _____

Definition of Eligibility – Eligible employees must be working at the Employer's usual place of business. Employees not regularly working at least 30 hours per week are considered part-time. (Foreign national employees are eligible for coverage while residing in the United States.

Employee Eligibility Includes: (check one)

☐ All full-time non-union employees

☐ All full-time employees* Does your firm employ union members? ☐ Yes ☐ No

☐ All full-time salaried employees

☐ Other (specify)*:

* Partnerships Only – Eligibility includes partners/owners who are working full-time for this Employer. ☐ Yes ☐ No

The above definition applies to: ☐ All Coverages

Applies only to: ☐ Life/AD&D ☐ Dental ☐ Medical ☐ Long Term Disability ☐ Short Term Disability
☐ Voluntary Life/AD&D ☐ Voluntary Dental ☐ Voluntary LTD ☐ Voluntary STD

Dependent Eligibility Includes:

☐ Spouse ☐ Registered Domestic Partner (CA Only)

☐ Child(ren) ☐ Domestic Partner (Coverage may not be available in all states)

If electing Domestic Partner Coverage, please indicate: ☐ Same-Sex Only ☐ Opposite-Sex Only ☐ Both

The above definition applies to: ☐ All Coverages

Applies only to: ☐ Dependent Life ☐ Dental ☐ Medical ☐ Long Term Disability (Survivor Benefits Only)
☐ Short Term Disability (Survivor Benefits Only) ☐ Voluntary Dependent Life ☐ Voluntary Dental
☐ Voluntary LTD (Survivor Benefits Only) ☐ Voluntary STD (Survivor Benefits Only)

Definition of Earnings

Important: "Basic Earnings" means an employee's gross rate of earnings from the Employer. It includes employee pre-tax

contributions to a qualified deferred compensation plan, 401(k) Plan, or Section 125 Plan. This definition defines the base against which the premium and benefits will be paid. If any employee's compensation is not reported on a W-2, or if any employee is paid on a basis other than salaried or hourly, please provide specifics. The term "Basic Earnings" refers to: an annual amount for Life/AD&D, a weekly amount for Short Term Disability, and a monthly amount for Long Term Disability.

☐ Basic Earnings **excluding** overtime, bonuses or other compensation

This definition applies to: ☐ All Coverages ☐ All Classes
Applies only to: ☐ Life ☐ STD ☐ LTD
☐ Applies only to class _____

Earnings are based on: ☐ Current level of earnings, or ☐ Prior calendar year earnings

☐ Basic Earnings **excluding** other compensation or overtime but including: ☐ Commissions ☐ Bonuses

This definition applies to: ☐ All Coverages ☐ All Classes
Applies only to: ☐ Life ☐ STD ☐ LTD
☐ Applies only to class _____

☐ Basic Earnings
☐ Commissions
☐ Bonuses

are based on the average of the latest: ☐ 24 months, ☐ 36 months, ☐ Prior calendar year earnings, ☐ Prior two calendar years, or ☐ Prior three calendar years

(For Partners Only) Average earning calculated from the partnership federal income tax return for the immediately prior:
☐ Tax Year ☐ Calendar Year

This definition applies to: ☐ All Coverages ☐ All Classes
Applies only to: ☐ Life ☐ STD ☐ LTD
☐ Applies only to class _____

REPLACEMENT OF EXISTING COVERAGE

Life

Will the SLHIC (U.S.) coverage replace any existing Group Life Coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:
Effective date of existing Group Life Coverage: _____
Does your existing group life coverage have a waiver of premium/extension of benefits provision for employees who are disabled?
☐ Yes ☐ No

Voluntary Life

Will the SLHIC (U.S.) coverage replace any existing Group Life Coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:
Effective date of existing Group Life Coverage: _____
Does your existing group life coverage have a waiver of premium/extension of benefits provision for employees who are disabled?
☐ Yes ☐ No

Dental ☐ **Traditional** ☐ **Voluntary** ☐ **Administrative Services Only**

Will the SLHIC (U.S.) coverage replace any existing Group Dental Coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:
Effective date of existing Group Dental Coverage: _____
Effective date of existing Orthodontia Coverage: _____
List any plan changes and their effective date(s) for the past five years:
_____
List any changes in insurance carrier(s) and the effective date(s) in the past five years:
_____

Short Term Disability ☐ **Traditional** ☐ **Voluntary**

Will the SLHIC (U.S.) coverage replace any existing Group Short Term Disability coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:

Effective date of existing Group Short Term Disability Coverage: _____

List any plan changes and their effective date(s) for the past five years:

_____

List any changes in insurance carrier(s) and the effective date(s) in the past five years:

_____

Long Term Disability ☐ **Traditional** ☐ **Voluntary**

Will the SLHIC (U.S.) coverage replace any existing Group Long Term Disability coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:

Name of current carrier: _____

Effective date of existing Group Long Term Disability Coverage: _____

Cancellation date of existing coverage: _____

List any plan changes and their effective date(s) for the past five years:

_____

List any changes in insurance carrier(s) and the effective date(s) in the past five years:

_____

Fully-Insured Medical

Will the SLHIC (U.S.) coverage replace any existing group medical coverage? ☐ Yes ☐ No coverage currently exists

If "yes", then please complete the following:

Effective date of existing group medical coverage _____

List any plan changes and their effective date(s) for the past five years:

_____

List any changes in insurance carrier(s) and the effective date(s) in the past five years:

_____

Stop Loss

Will the SLHIC (U.S.) stop loss insurance coverage replace any existing:

Group medical coverage? ☐ Yes ☐ No

Stop loss coverage? ☐ Yes ☐ No

If "yes", then please complete the following:

Effective date of existing Coverage: _____

List any plan changes and their effective date(s) for the past five

_____

List any changes in insurance carrier(s) and the effective date(s) in the past five years:

_____

Please note employees not actively at work are not covered until they return to work, unless required by applicable state law or approved in writing by the SLHIC (U.S.) Underwriting Department. Dependents must not be confined in any institution for medical care or treatment, or confined at home or elsewhere (or totally disabled with respect to Stop Loss insurance) on their coverage effective date. This paragraph does not apply to fully-insured medical coverage.

We require a copy of the current Plan Booklet/Certificate as well as the latest monthly bill showing employees who are covered under the plan.

Employer Statement

Please answer the following questions:

1. Is Employer presently insured with Sun Life and Health Insurance Company (SLHIC (U.S.)) or has Employer previously applied for, or had SLHIC (U.S.) group insurance coverage? ☐ No ☐ Yes

If "yes", indicate Account Number _____and Cancellation Date (if any) _____

2. Is Employer in the process of filing or contemplating the filing of bankruptcy or seeking protection from creditors whether insolvency (Chapter 7), reorganization (Chapter 11), or similar insolvency proceeding? ☐ No ☐ Yes

If "yes", explain: _____

_____

3. Is this an employer-sponsored program? ☐ No ☐ Yes

ERISA Information

Please complete the following if the plan: is an ERISA Plan and the Employer is requesting a Summary Plan Description.

ERISA Plan No. _____(e.g. 501 502) ERISA Plan Year _____(e.g. 1/1 – 12/31)

The Undersigned employer has/will employ _____ at _____

(Name) (Street Address)

_____, _____, _____ _____-_____-_____ as its Plan Administrator.

(City) (State) (Zip) (Area Code and Phone Number)

The undersigned employer has/will employ _____ at _____

(Name) (Street Address)

_____, _____, _____ _____-_____-_____as its agent for legal process.

(City) (State) (Zip) (Area Code and Phone Number)

Request for Participation

The undersigned employer requests that it be approved as a participant in the fund(s) and accepts and agrees to be bound by the terms of the trust agreements as amended. The undersigned employer further requests that insurance be provided in accordance with the Employer's specifications for group insurance to which this request is attached and shall be subject to the terms of the group insurance policy or policies issued to the trustee(s) by Sun Life and Health Insurance Company SLHIC (U.S.). The undersigned employer agrees that it will remit to the SLHIC (U.S.) or the trustee(s) regularly in advance the required premiums as they become due. Further, the undersigned employer hereby irrevocably designates SLHIC (U.S.) as the claims administrator and claim appeals fiduciary of its group insurance policy or policies for purpose of ERISA, if applicable.

The undersigned employer has read this and understands that:

1. This request for coverage is not effective until approved by SLHIC (U.S.) in writing. Coverage may be declined or the effective date may be deferred for incomplete submission of information as outlined in SLHIC (U.S.)'s underwriting rules/standards. **Existing coverage must not be terminated until written approval has been received.**
2. All information given in connection with this request for participation is true and complete to the best of knowledge, information and belief.
3. SLHIC (U.S.) reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete.
4. No producer can make or modify a contract for SLHIC (U.S.) and all coverage will be as stated in SLHIC (U.S.) policies.
5. Attached is an initial deposit check payable to SLHIC (U.S.) equal to the **estimated first month's premium.** The amount will be returned if insurance does not become effective. Cashing of the check by SLHIC (U.S.) does not constitute an acceptance of the risk or approval of this request for coverage.
6. Final premium rates are subject to final enrollment and any prior claim history that we may require.
7. When you purchase insurance from us, we pay compensation to the producer and/or to any agency through which the producer works. If the producer works through an agency, the agency may pay compensation directly to the producer. Compensation may include commissions when a policy is purchased or renewed, and fees for other services. The compensation may vary by the type of insurance purchased. Additionally, bonuses and incentive trips or awards associated with sales may be paid based on the overall sales volume or persistency of business. The compensation that we pay to producers may differ from that paid by other insurance companies. If you have questions, contact your producer directly.
8. 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 state 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 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 containing any false, incomplete or misleading information is guilty of a felony of the third degree."
IN LOUISIANA: "Any person knowingly presents a false claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime any may be subject to fines and confinement in prison."
IN NEW JERSEY: "Any person who knowingly files a statement or claim containing any false or misleading information 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 containing 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."
IN PUERTO RICO: "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand ($5,000) dollars nor more than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

Employer Name	Date Signed (MM/DD/YYYY)	Employer Location
Signed by (Signature of Authorized Employer Representative) & Print		Title
Selling Producer's Name and Address	Selling Producer Insurance License Number (State and Number)	Commission Receiving Producer Insurance License (State and Number)
By signing this form, the Selling Producer represents that s/he is licensed in the state where the employer is located and has been appropriately appointed by Sun Life and Health Insurance Company (U.S.), as required by applicable state law. Also Producer understands and acknowledges that collection and remittance of producer compensation based upon fees, not premium, if any, is an accommodation to the Employer and producer. Further Producer acknowledges that Sun Life and Health Insurance Company (U.S.) assumes no responsibility for modification of any producer compensation based upon fees, not premium, if any.		
Selling Producer's Signature	Selling Producer's Phone Number	Selling Producer's E-Mail Address

Coverage Continuation Administration

Are you currently administering your:

COBRA Continuation ☐ Yes ☐ No

State Continuation ☐ Yes ☐ No

For California Employers Only:

Do you want Sun Life and Health Insurance Company (U.S.) to administer your Cal-COBRA benefits? ☐ Yes ☐ No

*COBRA is a federal law that permits group health plan participants to continue their health plan coverage **after** a loss of coverage due to certain events, e.g., divorce, death of a spouse or attaining limiting age.

Continuance of Coverage For Medical and/or Dental Insurance

Provisions That May Be Affected By Federal Legislation:

Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)? ☐ Yes ☐ No

If 'yes', do you wish to have maximum coverage period measured from actual qualifying event or from the loss of coverage?

☐ Qualifying Event

☐ Loss of Coverage (use Loss of Coverage if termination of coverage is at the end of the month)

☐ Coverage terminates at end of the month in which the employee terminates (Requires: Loss of coverage, COBRA election AND waiting period with a first of the month effective date.)

Are any individuals currently being continued for Medical or Dental coverage due to COBRA or State requirements? ☐ Yes ☐ No
If 'yes' please complete the section below which provides us with information about each individual.

COVERED PERSON'S NAME (Last, First, M. Initial)	SOCIAL SECURITY NO.	GENDER	STATUS E OR D*	DATE OF BIRTH	HEALTH PLAN ELECTED MEDICAL S OR F	HEALTH PLAN ELECTED DENTAL S OR F	DATE CONTINUANCE BEGAN	DATE CONTINUANCE ENDS	C = COBRA S = STATE
	- -			/ /			/ /	/ /	
	- -			/ /			/ /	/ /	
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E=Employee or D=Dependent

NOTE: The same level of benefits must be available under the continuance as would have been available had the individual remained under the employer's plans for active participants.