Group benefits enrolment form

Sun Life Financial

Instructions

- Section 1 is to be completed by the plan administrator.
- All remaining sections are to be completed by the plan member.
- Complete the form in ink, sign and date the form.
- Please PRINT clearly.

1 Information to be completed by plan administrator

Contract Number	Contractholder name		
☐ New plan member ☐ Re-hire	Date of hire/re-hire (yyyy/mmm/dd)	Plan member ID	Class/Plan
Effective date of coverage (yyyy/mmm/dd)	Location/billing group number	Location/billing group name	
Occupation	Salary $	Basis ☐ Annual ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Weekly ☐ Hourly (Hrs./Wk. _____) ☐ Other _____ (please specify)	

2 Plan member details

Plan member's name (first, middle initial, last)			Gender ☐ Male ☐ Female
Address (street number and name, apartment or suite)			
City		Province	Postal Code
Date of birth (yyyy/mmm/dd)	Language ☐ English ☐ French	Province of residence	Province of employment
Marital status ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Common Law ☐ Widowed ☐ Civil Union			Coverage selection ☐ Single ☐ Family

3 Refusal of benefits

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group contract you may refuse to be covered for such benefit(s) under this contract by selecting the applicable box for each benefit:

I refuse coverage for myself and my dependents under: ☐ **Extended Health Care** ☐ **Dental Care**

I refuse coverage for my dependents under: ☐ **Extended Health Care** ☐ **Dental Care**

4 Spouse details

Complete this section only if you are applying for coverage for your spouse.

Spouse's name (first, last)	Gender ☐ Male ☐ Female	Date of birth (yyyy/mmm/dd)

Is your spouse covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?
☐ Yes ☐ No If *Yes*, please indicate spouse's coverage:

Dental Care ☐ Family ☐ Single

Extended Health Care ☐ Family ☐ Single Name of Benefits Carrier: _____

5 Children details

Complete this section only if you are applying for coverage for your children.

IMPORTANT:

1. A spouse must first claim from his/her own employer's plan.
2. Claims for covered children must be sent first to the plan of the parent whose birth date falls earlier in the year.

		Gender	Student*	Overage disabled child**
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

***** A student is a child age 21 or over but under age 25, who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.
(For Quebec Plan members please check with your plan administrator for dependent student age limit.)

****** To enrol an overage disabled child, complete a Handicapped Child Coverage Form, and send it to us within 31 days of the date the dependent reaches the age limit.

6 Beneficiary nomination

IMPORTANT:
Be sure to show the beneficiary's first and last name, as well as the relationship to you.

You must initial any changes or deletions. Correction fluid cannot be used.

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

If you are nominating a beneficiary who is a minor, please see section 8.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ Revocable		

7 Appointing contingent beneficiaries

If you wish to appoint a contingent beneficiary, in the event that there are no surviving beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Unless I specify otherwise, my contingent beneficiary will apply to all my benefits.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage

8 Trustee nomination for minor beneficiary

If you wish to designate minor children as beneficiaries, a Trustee/Administrator must be designated. In Quebec, "Trustee" shall be understood as "Administrator", and the obligations of the Administrator shall be interpreted in accordance with the Quebec Civil Code.

Any payments becoming due while the beneficiary(s) are a minor*, are to be made to

_____ as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to the trustee will discharge the company.

* A minor is a child who has not reached the age of majority as defined by provincial legislation.

9 Authorization and signature

IMPORTANT:
You must sign and date the form.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan.

By enrolling in this Plan, I authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims,
- My plan sponsor, and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Sun Life Assurance Company of Canada, its agents and service providers, and my plan sponsor and its agents to use and exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

A photocopy or electronic version of this authorization is as valid as the original.

Plan member signature	Date (yyyy/mmm/dd)
X	

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies is committed to keeping your information confidential.