

Sun Life Financial

Group Enrollment form



Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

1. General Information

Employer Name Arrowhead Economic Opportunity Agency	Account / Policy Number 927528	Location	Date Effective
Street Address	City	State MN	Zip Code
Type of activity: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason:		Occupation	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Street Address		City	State	Zip Code
Marital Status	Social Security Number		Phone Number	
Date employed: <input type="checkbox"/> Full-Time Date:	<input type="checkbox"/> Part-Time Date:	<input type="checkbox"/> Rehire Date:	<input type="checkbox"/> Return from layoff Date:	
Current Active Employment Type _____ # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee Status: <input type="checkbox"/> Management <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired		Salary	

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is. See the Evidence of Insurability section for details.

3. Benefit Elections

Life Coverage: underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

Dependent Basic Life Insurance Elect Refuse

Coverage Option Selected _____

	Elect	Refuse	Coverage amount elected
	Life	Life	
Employee Coverage:	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Spouse Coverage: **	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Child(ren) Coverage: **	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____

** Spouse and children may only be covered if you are. You cannot elect more than 100% of the amount of Voluntary Insurance you have elected for yourself for your spouse and more than 50% of the amount of Voluntary Insurance you have elected for yourself for your child(ren).

4. Dependent Information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full Legal Name (First, Middle Initial, Last)	Gender	Social Security No.	Date of Birth	Check if elected
					Dep Life
Spouse or Partner					<input type="checkbox"/>
Children					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

5. Beneficiary Designation Information

Primary Beneficiary Designation

Employee Basic Life and AD&D Insurance - 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. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	
2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

Employee Voluntary Life Insurance - 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. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	
2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

Secondary Beneficiary Designation

Employee Basic Life and AD&D Insurance - 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. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	
2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

Employee Voluntary Life Insurance - 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. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	
2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

6. Evidence of Insurability and authorization information

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for higher coverage than the maximum Guaranteed Issue amount.
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier.
- decline coverage and then want it at a later date.

Coverage subject to evidence of insurability will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.). I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

Signature of employee X	Date signed
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To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

7. Employer Information

For Employer Use Only.

Provide the employee's earnings amount below.

Indicate 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.

Life Earnings \$	<input type="checkbox"/> Annual	<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: _____	

Contact us



By mail

Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.)
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www.sunlife.com/us



Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET

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