Sun Life

One Sun Life Executive Park, Wellesley Hills, MA 02481

Group Enrollment Form

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

Employer use (check one): ☐ New employee ☐ Change ☐ COBRA

1. General Information

Employer Name	**Account / Policy Number**	**Location**
Jefferson County Commission	978200	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)	☐ Male ☐ Female	**Date of Birth**

Street Address	**City**	**State**	**Zip Code**

Occupation	**Eligibility Class** (if applicable)	**Social Security Number**	**Phone Number**

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Return from layoff Date: ☐ Rehire

Current Active Employment Type
# of hours ☐ Full-Time ☐ Part-Time

Earnings $ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other:

3. 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, M.I., Last)	Gender	Social Security number	Date of birth	Student Y / N
Spouse					
Children					

4. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below 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.

Elect	Refuse	Coverage
☐	☐	Dental: ☐ Employee ☐ Employee + 1 dependent ☐ Employee + 2 or more dependents Were you covered under another dental plan within the last 31 days? ..... ☐ Yes ☐ No If "Yes," provide the termination date: _____ Reason for termination of coverage? _____
☐	☐	Employee Voluntary Life $ _____
☐	☐	Spouse Voluntary Life $ _____
☐	☐	Child(ren) Voluntary Life $ _____

Employer provided benefits--Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

☑ Employee Basic Life and Accidental Death & Dismemberment (AD&D)

5. Beneficiary Designation Information

Primary Beneficiary Designation

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. Designation applies to all coverages for which a beneficiary designation is required.

Primary Beneficiary(ies)

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

*Must equal 100%

Secondary Beneficiary Designation

On the lines below, list the individual(s) who should receive the 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 a primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

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

*Must equal 100%

6. Signature and authorization information

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 applying for coverage more than 31 days past my eligibility date, Evidence of Insurability may be required.
- For Life, Short-Term Disability, and Long-Term Disability insurance, Evidence of Insurability may be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Life benefits may require Evidence of Insurability.
- 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, if required for the elected coverage(s), to be approved by Sun Life Assurance Company of Canada (Wellesley, MA). For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant benefit waiting period specified in the certificate of insurance.
- For Dental Insurance plans, I have the right to select any dental care provider of my choice.
- The dental plan includes a pre-determination provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- Coverages include benefit waiting periods, limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.
- 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.

X _____ _____

Employee Signature | Today's Date

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.