



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 Town of Swampscott	Account / Policy Number 939866	Location
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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
Occupation	Eligibility Class (if applicable)	Social Security Number		Phone Number
Date employed: <input type="checkbox"/> Full-Time Date: _____ <input type="checkbox"/> Part-Time Date: _____		<input type="checkbox"/> Return from layoff Date: _____ <input type="checkbox"/> Rehire		
Current Active Employment Type _____ # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Dental: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Family Were you covered under another dental plan within the last 31 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the termination date: _____ Reason for termination of coverage? _____
<input type="checkbox"/>	<input type="checkbox"/>	Short-Term Disability (STD) \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Long-Term Disability (LTD) \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	Accident: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
<input type="checkbox"/>	<input type="checkbox"/>	Critical Illness: Employee amount \$ _____ Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse amount \$ _____ Has your spouse used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Child(ren) amount \$ _____

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 Short-Term Disability, Long-Term Disability, and Critical Illness insurance, Evidence of Insurability may be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Short-Term Disability, Long-Term Disability, and Critical Illness 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.

Agent, Broker, and/or Enroller information:

Agent name
Agent / Broker name
Enroller name

Contact us



By mail

Sun Life
One Sun Life Executive Park
Wellesley Hills, MA 02481



www.sunlife.com/us



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