Sun Life Assurance Company of Canada

Group Enrollment Form

Sun Life Financial®

1. General Information

Employer Name	Account / Policy Number	Location	Date Effective
Pelham School District	241422		
Street Address	**City**	**State**	**Zip Code**
59A Marsh Road	Pelham	NH	03076
Type of activity: ☐ New Enrollment ☐ Change Reason:		**Occupation**	

2. Employee Information

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

You must elect or refuse insurance coverage below within 31 days of your date of eligibility by placing a check mark in the appropriate box(es). Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available and what your Maximum Guarantee Issue amount is. See "Evidence of Insurability" section for details.

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

	Elect Life	Refuse Life	Coverage amount elected	Non-Smoker	Smoker
Employee Coverage:	☐	☐	$ _____	☐	☐
Spouse Coverage: **	☐	☐	$ _____	☐	☐
Child(ren) Coverage: **	☐	☐	$ _____		

** Spouse and children may only be covered if you are. You cannot elect more than 100% of the amount of Optional Insurance you have elected for yourself for your spouse and 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					☐
Children					☐
					☐
					☐

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 Optional 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 Optional 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

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 $	☐ Annual ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly	☐ Hourly 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.)
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

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