Sun Life Financial

Group Enrollment form

Sun Life Financial®

☐ 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	**Account / Policy Number**	**Location**	**Date Effective**
Mayor and City Council of Ocean City	959977		
Street Address	**City**	**State**	**Zip Code**
		MD	
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.

3. Benefit Elections

Voluntary AD&D Coverage; underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

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

** Spouse and children may only be covered if you are. You cannot elect more than 50% of the amount of Voluntary 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 Vol AD&D
Spouse or Partner					☐
Children					☐
					☐
					☐

5. Beneficiary Designation Information

Primary Beneficiary Designation

Voluntary 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%

Secondary Beneficiary Designation

Voluntary 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%

6. 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 I decline coverage for Voluntary AD&D and do not enroll when I am eligible, I will not be allowed to enroll for at least 6 months.
- 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. Fraud Warning

Please read the fraud warning below before signing the Enrollment Form. State law requires that we notify you of the following:

Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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