Group Enrollment Form

For use by: Sun Life Assurance Company of Canada and
Sun Life and Health Insurance Company (U.S.) outside of New York

Sun Life Financial®

Complete all sections of the Group Enrollment Form and return to: The McKellan Group, Inc., 1449 Old Waterbury Rd Suite 201 Southbury, CT 06488 . Questions, call, 800-531-2001 or fax to: 203-575-0308. Make sure you complete and sign the form during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

Employer name	Account/Policy number	Location	Date effective
Street address	City	State	Zip code
Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation		
Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:			

Employee Information

Employee's Full Legal Name (First, MI, Last) ☐ Male ☐ Female	Date of Birth	Marital Status	Social Security No.
Street Address	City	State	Zip Code
Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary	

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.

Life and Disability coverage: Underwritten by [Sun Life Assurance Company of Canada (Wellesley, MA)] [Sun Life and Health Insurance Company (U.S.) (Wellesley, MA)]

Employee Basic Life [and AD&D]..... ☐ Elect ☐ Refuse
Dependent Basic Life [and Dep AD&D]... ☐ Elect ☐ Refuse

Employee Short Term Disability ☐ Elect ☐ Refuse
Percent Elected ☐XX% ☐ XX% ☐ XX%
Optional Buy Up to XX% ☐ Elect ☐ Refuse
Coverage amount selected _____*
*Amount is limited to XX% of the Basic Weekly Earnings

Employee Long Term Disability..... ☐ Elect ☐ Refuse
Percent Elected..... ☐ XX% ☐ XX%.... ☐ XX%
Optional Buy Up to XX% ..... ☐ Elect ☐ Refuse
Coverage amount selected..... _____*
*Amount is limited to XX% of the Basic Monthly Earnings

Optional Life and AD&D coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

	Elect		Refuse				
	Life	AD&D	Life	AD&D	Coverage amount elected	Non-Smoker No Tobacco	Smoker Tobacco
Employee coverage:	☐	☐	☐	☐	Life: AD&D:	☐	☐
Spouse coverage**:	☐	☐	☐	☐	Life: AD&D:	☐	☐
Child(ren) coverage**:	☐	☐	☐	☐	Life: AD&D:		

** Spouse and Children may only be covered for Optional Life if you are. Spouse and Child(ren) are not eligible for Optional AD&D.
You cannot elect more than 50% of your amount of [Voluntary] [(Optional)] insurance for your spouse and child(ren) than [you have elected for yourself][what you are insured for under the group policy].yourself.

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, MI, Last)	Gender	Social Security No.	Date of Birth	Check if elected	
					Dep Life	Dep Dental
Spouse / Partner			XXX-XX-		☐	☐
Children			XXX-XX-		☐	☐
			XXX-XX-		☐	☐
			XXX-XX-		☐	☐

Primary Beneficiary Designation

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.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Optional 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.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Secondary Beneficiary Designation

Basic Life and AD&D Insurance– 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 your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Optional Life and AD&D Insurance– 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 your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

Evidence of Insurability:

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 a 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][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][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.
- 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][Sun Life and Health Insurance Company (U.S.)]. I have read the Evidence of Insurability notice.
- I have read the Fraud Warning below.
- 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 verifying 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.

For Employer Use Only

Provide the employee's earnings amount below. Most employers should use the "All Coverages" box only. However, if your group policy requires that you calculate separate earnings amounts by coverage, please enter those amounts in the second set of boxes.

Indicate whether earnings amount is annual pay, or some other 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.

All Coverage Earnings $	☐ Annual ☐ Monthly	☐ Semi-Monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____

Life Earnings $	☐ Annual ☐ Monthly	☐ Semi-Monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____
STD Earnings $	☐ Annual ☐ Monthly	☐ Semi-Monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____
LTD Earnings $	☐ Annual ☐ Monthly	☐ Semi-Monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____

Fraud Warnings

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

General Fraud Warning:	Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.
Colorado Fraud Warning:	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia and Rhode Island Fraud Warning:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Florida Fraud Warning:	ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.
Kansas Fraud Warning:	Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.
Kentucky Fraud Warning:	Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects that person to criminal and civil penalties.
Maryland Fraud Warning:	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey Fraud Warning:	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Oregon Fraud Warning:	Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.
Tennessee, Virginia and Washington Fraud Warning:	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Vermont Fraud Warning:	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.