Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
Attn: Group Eligibility - WIN 407
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

ENROLLMENT REQUEST

☐ Add ☐ Change ☐ Termination ☐ Correction

Date: _____ Reason: _____

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group

4. Name of Employer

5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.)	7. Social Security Number
8. Employee's Address (Number, Street, City, State, ZIP Code)	9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female	11. Date of Birth (Mo., Day, Yr.)	12. Marital Status ☐ Single ☐ Married	13. My employment is covered under Union Collective Bargaining ☐ Yes
14. Hours worked weekly for this employer (Excluding Overtime)_____ ☐ Active ☐ Retired		15. Date Employed (Mo., Day, Yr.) ☐ Full-Time _____ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___	
16. Basic Earnings $ _____ ☐ Hourly _____ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually		17. Employee's Occupation (Title)	

NOTE: If you refuse Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) does not imply liability for SLHIC (U.S.) for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Dental ☐ I Elect ☐ I Refuse	Dependent Dental ☐ I Elect ☐ I Refuse
If you have refused Dental, is it because you have other Group Coverage?	If you have refused Dental for your dependents, is it because they have other Group

If Other Coverage Has Been Entered It Will Appear on the Following Page(s)

Please complete this *entire* section if you are selecting Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: _____

School Name and Address: _____

Course of Study: _____

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date	25. Signature

Employee Name: ______________________________ Social Security Number: ______________________________

Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number