Sun Life

One Sun Life Executive Park, Wellesley Hills, MA 02481

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	**Account / Policy Number**	**Location**
Saint Francis University	961357	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last) ☐ Male ☐ Female			**Date of Birth**
Street Address	**City**	**State**	**Zip Code**
Occupation	**Eligibility Class** (if applicable)	**Social Security Number**	**Phone Number**

Date employed: ☐ Full-Time Date: ☐ Return from layoff Date:
☐ Part-Time Date: ☐ Rehire

Current Active Employment Type	**Earnings** $
_____ # of hours ☐ Full-Time ☐ Part-Time	☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ 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.

Elect	Refuse	Coverage
☐	☐	Dental:

☐ Employee ☐ Employee + Spouse
☐ Employee + Child(ren) ☐ Employee + Family

Were you covered under another dental plan within the last 31 days? ..... ☐ Yes ☐ No

If "Yes," provide the termination date: _____

Reason for termination of coverage? _____

5. 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.
- 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 and exclusions 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.
- 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 such person to criminal and civil penalties.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief. I have read or had read to me the fraud warning for my state.

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