Group benefits enrolment/change form for plans with Optional Life and Critical Illness

Sun Life Financial

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Instructions

- Section 1 is to be completed by the plan administrator.
- All remaining sections are to be completed by the plan member and returned to your plan administrator.

Please PRINT clearly. Complete the form in ink, sign and date the form on page 4 and return to your plan administrator for handling.

1 Information to be completed by plan administrator

☐ **Enrolment form**
(Complete all sections)

☐ **Change form**
(Only complete the information that is changing and include the effective date of change)

☐ **Beneficiary** ☐ **Dependent Status** ☐ **Termination** ☐ **Salary/Wages**

☐ **Other** (please specify) _____

Contract number	Contract holder name		
☐ New plan member ☐ Re-hire	Date of hire/re-hire (yyyy-mm-dd)	Plan member ID	Class/Plan
Effective date of coverage/change (yyyy-mm-dd)	Location/billing group number	Location/billing group name	
Occupation	Salary $	Basis ☐ Annual ☐ Monthly ☐ Bi-weekly ☐ Semi-monthly ☐ Weekly ☐ Hourly (Hrs./Wk. ____) ☐ Other ____ (please specify)	

2 Plan member details

Plan member's last name	Middle initial	First name	Gender ☐ Male ☐ Female
Address (street number and name)			Apartment or suite
City	Province	Postal code	
Date of birth (yyyy-mm-dd)	Language ☐ English ☐ French	Province of residence	Province of employment
Marital status ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Divorced ☐ Separated ☐ Widowed			Coverage selection ☐ Single ☐ Family

3 Refusal of benefits

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group contract you may refuse to be covered for such benefit(s) under this contract by selecting the applicable box for each benefit:

I refuse coverage for myself and my dependents under: ☐ **Extended Health Care** ☐ **Dental Care**

I refuse coverage for my dependents under: ☐ **Extended Health Care** ☐ **Dental Care**

4 Spouse details

Complete this section only if you are applying for coverage for your spouse.

***U (Update codes):**

A = Addition

C = Change

T = Termination

*U	Effective date (yyyy-mm-dd)	Spouse's last name	Spouse's first name	Gender	Date of birth (yyyy-mm-dd)
	– –			☐ Male ☐ Female	– –

Is your spouse covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?

☐ No ☐ Yes If *yes*, please indicate spouse's coverage:

Extended Health Care ☐ None ☐ Single ☐ Family

Dental Care ☐ None ☐ Single ☐ Family

Name of benefits carrier: ______________________

5 Children details

Complete this section only if you are applying for coverage for your children.

IMPORTANT:

1. A spouse must first claim from his/her own employer's plan.
2. Claims for covered children must be sent first to the plan of the parent whose birth date falls earlier in the year.

*U	Effective date (yyyy-mm-dd)	Child's last name	Child's first name	Date of birth (yyyy-mm-dd)	Gender	Student*	Over-age disabled child**
	– –			– –	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
	– –			– –	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
	– –			– –	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
	– –			– –	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

***** A student is a child age 21 or over but under age 25, who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.

(For Quebec Plan members please check with your plan administrator for dependent student age limit.)

****** To enrol an over-age disabled child, complete a Disabled Child Coverage form, and send it to us within 31 days of the date the dependent reaches the age limit.

6 Optional Life, Accidental Death and Dismemberment (AD&D) and/or Critical Illness benefits

Complete only for the optional benefits that you are electing or changing.

Your plan administrator will advise you which of these benefits are offered under your plan and how much coverage you can select.

Your spouse must complete and sign the Spouse Optional Life/Critical Illness information in the right hand column if you are electing this coverage.

Optional Life

☐ Plan member ☐ Add ☐ Change ☐ Terminate	☐ Spouse (Spouse must complete and sign) ☐ Add ☐ Change ☐ Terminate
Amount of coverage $	Amount of coverage $

Optional Critical Illness

☐ Plan member ☐ Add ☐ Change ☐ Terminate	☐ Spouse (Spouse must complete and sign) ☐ Add ☐ Change ☐ Terminate
Amount of coverage $	Amount of coverage $
Have you used tobacco products within the past 12 months? ☐ Yes ☐ No	Have you used tobacco products within the past 12 months? ☐ Yes ☐ No
	Spouse's date of birth (yyyy-mm-dd) – –
	I declare that the information above is accurate and true. Inaccurate information may invalidate my claim. Spouse's signature X ______________

Child Optional Life

☐ Each child

☐ Add ☐ Change ☐ Terminate

Amount of coverage
$

6 Optional Life, Accidental Death and Dismemberment (AD&D) and/or Critical Illness benefits (continued)

Child Optional Critical Illness

☐ Each child

☐ Add ☐ Change ☐ Terminate

Amount of coverage
$

Optional AD&D

☐ Plan member

☐ Add ☐ Change ☐ Terminate

Amount of coverage
$

☐ Spouse

☐ Add ☐ Change ☐ Terminate

Amount of coverage
$

☐ Each child

☐ Add ☐ Change ☐ Terminate

Amount of coverage
$

7 Beneficiary nomination

IMPORTANT:
Complete each section for any benefits for which you are applying.

Be sure to show the beneficiary's first and last name, as well as the relationship to you.

You must initial any changes or deletions. Correction fluid cannot be used.

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

If you are nominating a beneficiary who is a minor, please see section 10.

NOTE: In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf.

By completing this section I revoke all previously nominated beneficiary nominations and make the following nomination where permitted by law.

☐ Beneficiary for **Employee BASIC Life** and **Accidental Death Benefits (if applicable)**

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

☐ Beneficiary for **Employee OPTIONAL Life** and **Accidental Death Benefits (if applicable)**

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

If you do not nominate a beneficiary, the proceeds will be paid to your estate.

8 Spouse beneficiary nomination (to be completed by the plan member)

Complete this section if you are applying for or changing spouse optional coverage.

By completing this section I revoke all previously nominated beneficiary nominations and make the following nomination where permitted by law.

☐ Beneficiary for **Spouse OPTIONAL Life** and **Accidental Death Benefits (if applicable)**

You may nominate yourself or someone other than your spouse as the beneficiary.

If no beneficiary is nominated, you are automatically the beneficiary.

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%

9 Appointing contingent beneficiaries

If you wish to appoint a Contingent Beneficiary, in the event that there are no surviving beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Unless I specify otherwise, my Contingent Beneficiary will apply to all my benefits. I revoke all previous Contingent Beneficiary appointments.

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

10 Nomination of trustee for minor beneficiary other than Quebec residents

If you wish to designate minor children as beneficiaries, a trustee must be designated.

NOTE: In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf.

Any payments becoming due while the beneficiary(s) are a minor* are to be made to

_____ as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to the trustee will discharge the company.

* A minor is a child who has not reached the age of majority as defined by provincial legislation.

11 Authorization and signature

IMPORTANT:

You must sign and date the form.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the plan.

By enrolling in this plan, I authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers, its reinsurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims,
- My plan sponsor, and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Sun Life Assurance Company of Canada, its agents and service providers, and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Optional Employee Life or Optional Spousal Life and for myself, my spouse or child(ren) to become covered or to increase Optional Critical Illness coverage.

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

A photocopy or electronic version of this authorization is as valid as the original. A photocopy or electronic version of this form is not valid for recording beneficiary nominations.

Plan member signature	Date (yyyy-mm-dd)
X	– –