

Sun Life Financial

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 City of Springfield	Account / Policy Number 919296	Location
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2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Street Address	City	State	Zip Code
Occupation	Eligibility Class (if applicable)	Social Security Number	Phone Number
Date employed: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Date: _____	<input type="checkbox"/> Return from layoff <input type="checkbox"/> Rehire	Date: _____
Current Active Employment Type _____ # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Earnings \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Dental: <input type="checkbox"/> Basic (Low Plan) <input type="checkbox"/> Enhanced (High Plan) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents
Were you covered under another dental plan within the last 31 days? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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.

By signing below, I am representing 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.

Agent, Broker, and/or Enroller information:

Agent name
Agent / Broker name
Enroller name

Contact us



By mail

Sun Life Financial
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