Sun Life®

SUN LIFE ASSURANCE COMPANY OF CANADA
Executive Office: 96 Worcester Street, Wellesley Hills, MA 02481
(800) 247-6875 www.sunlife.com/us

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioner's website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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**
Stonehill College, Inc.	978287,978286	

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

Current Active Employment Type
_____ # of hours ☐ Full-Time ☐ Part-Time

Earnings $ ☐ 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 and what your Maximum Guaranteed Issue amount is.

Elect	Refuse	Coverage
☐	☐	Employee Voluntary Life and Accidental Death & Dismemberment (AD&D) $
☐	☐	Spouse Voluntary Life and Accidental Death & Dismemberment (AD&D) $
☐	☐	Child(ren) Voluntary Life and Accidental Death & Dismemberment (AD&D) $

4. Benefit Elections (continued)

Elect	Refuse	Coverage
☐	☐	Accident: ☐ STANDARD / 24 hr ☐ ENHANCED / 24 hr ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
☐	☐	Critical Illness: Employee amount $ _____ Spouse amount $ _____ Child(ren) amount $ _____
☐	☐	Hospital Indemnity: ☐ LOW ☐ HIGH ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family Have you used tobacco in any form in the past 12 months? ..... ☐ Yes ☐ No

Employer provided benefits--Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

☑ Employee Basic Life and Accidental Death & Dismemberment (AD&D)

☑ Long-Term Disability (LTD)

5. Beneficiary Designation Information

Primary Beneficiary Designation

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. Designation applies to all coverages for which a beneficiary designation is required.

Primary Beneficiary(ies)

			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

*Must equal 100%

Secondary Beneficiary Designation

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 a primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

*Must equal 100%

6. 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.
- If applying for coverage more than 31 days past my eligibility date, Evidence of Insurability may be required.
- For Life, Long-Term Disability, and Critical Illness insurance, Evidence of Insurability may be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Life and Critical Illness benefits may require Evidence of Insurability.
- 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, if required for the elected coverage(s), to be approved by Sun Life Assurance Company of Canada (Wellesley, MA).
- Coverages may include benefit waiting periods, limitations, exclusions and a pre-existing conditions provision 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
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Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET