

Enrolment form with Optional Life (with Member Address)



Please PRINT clearly. Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Member details

Contract number		Contract holder name			
<input type="checkbox"/> New member <input type="checkbox"/> Re-hire	Date of Hire/Re-hire (yyyy/mmm/dd)	Member ID number:	<input type="checkbox"/> Social Insurance Number	<input type="checkbox"/> Payroll	<input type="checkbox"/> Certificate
Effective date of coverage (yyyy/mmm/dd)	Location/billing group number	Location/billing group name	Class/Plan		
Member name (first, middle initial, last)					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Member address (street number and name, apartment or suite)					
City		Province	Postal Code		
Date of Birth (yyyy/mmm/dd)	Language <input type="checkbox"/> English <input type="checkbox"/> French	Member's province of residence	Member's province of employment		
Occupation					
Salary \$	Basis	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly (Hrs./Wk. _____)	<input type="checkbox"/> Other _____ (please specify)	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law	<input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	Dependent status	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Couple*
			<input type="checkbox"/> Single + 1 dependent*	<input type="checkbox"/> Single + 2 or more dependents*	
* use only if applicable to your plan					

2 Spouse details

Name (first, last)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (yyyy/mmm/dd)
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Is your spouse covered for Extended Health Care and/or Dental benefits by his/her employer's plan? Yes No
If Yes, please indicate spouse's coverage:

Dental Family Single
Extended Health Care Family Single Name of Carrier: _____

3 Children details

Canadian Life and Health Insurance Association Guidelines (CLHIA) state:

1. A spouse must first claim from his/her own employer's plan.
2. Covered children must first claim from the plan covering the parent with the earlier date of birth in the year.

Name (first, last)	Date of birth (yyyy/mmm/dd)	Gender	Student*
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Definition of 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 Members please check with your plan administrator for dependent student age maximum.)

4 Refusal of benefits

If you or your dependents are presently covered for Extended Health Care and/or Dental benefits under another group contract you may refuse to be insured for such benefit(s) under this contract by completing one or both of the following areas:

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

5 Optional life and accidental death and dismemberment benefits

Your plan administrator will advise you which benefits are provided under this contract.

Optional Life

Member

Amount of coverage, in multiples of \$10,000 _____

OR multiples of \$25,000 _____

OR _____ x salary

Have you used tobacco products within the past 12 months?

Yes No

Child Optional Life

Each Child Amount of coverage _____

Optional AD&D

Member Amount of coverage _____

Spouse Amount of coverage _____

Each Child Amount of coverage _____

Spouse (Spouse must complete and sign)

Amount of coverage, in multiples of \$10,000 _____

OR multiples of \$25,000 _____

OR _____ x salary

Have you used tobacco products within the past 12 months?

Yes No

Spouse's birth date (yyyy/mmm/dd) _____

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

Spouse's signature _____

6 Revocable beneficiary nomination

To be completed by the Member.

Beneficiary for Employee Basic Life and Accidental Death Benefits

Name (first, last)	Relationship to Member
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Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: Revocable

Beneficiary for Employee Optional Life and Accidental Death Benefits

Name (first, last)	Relationship to Member
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Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: Revocable

Beneficiary for Spouse Optional Life and Accidental Death Benefits

Name (first, last)	Relationship to Member
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Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: Revocable

Please note that according to legal requirements, Sun Life Assurance Company of Canada cannot pay benefits to beneficiaries who are minors. A trustee for minor children must be designated, except in Quebec.

Beneficiary Trustee Nomination

Any payments becoming due during the minority of the minor(s) to be made to _____ as Trustee, or failing such Trustee to the duly appointed guardian of such minor child as Trustee. Payment to said Trustee shall discharge the company.

7 Authorization and Signature

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 to use and exchange information collected in this form to underwrite, administer and adjudicate claims,
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required.

I understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Optional Employee or Optional Spouse Life 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.

Member Signature X	Date (yyyy/mmm/dd)
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