

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



Keeping Your Information Confidential

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To view our current privacy policy, please visit www.sunlife.ca.

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.
- Complete the form in ink, sign and date the form.
- Please PRINT clearly.

1 Information to be completed by plan administrator

Contract number		Contractholder name		
<input type="checkbox"/> New plan member <input type="checkbox"/> Re-hire	Date of hire/re-hire (yyyy/mm/dd)	Plan member ID		Class/Plan
Effective date of coverage (yyyy/mm/dd)		Location/billing group number		Location/billing group name
Occupation		Salary	Basis	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Other _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <small>(please specify)</small> <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Hourly (Hrs./Wk. _____)

2 Plan member details

Plan member's name (first, middle initial, last)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (street number and name, apartment or suite)				
City		Province		Postal code
Date of birth (yyyy/mm/dd)	Language <input type="checkbox"/> English <input type="checkbox"/> French		Province of residence	Province of employment
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced		<input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	Civil Union <input type="checkbox"/> Coverage selection <input type="checkbox"/> Single <input type="checkbox"/> 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.

Spouse's 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 Care benefits by his/her employer's plan?
 Yes No If Yes, please indicate spouse's coverage:

Dental Care Family Single

Extended Health Care Family Single 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.

Child's name (first, last)	Date of birth (yyyy/mmm/dd)	Gender	Student*	Overage disabled child**
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 overage disabled child, complete a Handicapped Child Coverage Form, and send it to us within 31 days of the date the dependent reaches the age limit.

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

Complete this section only if you are requesting optional benefits.

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

Amount of coverage _____

Spouse (Spouse must complete and sign)

Amount of coverage _____

Critical Illness

Plan member

Amount of coverage _____

Spouse (Spouse must complete and sign)

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

Child Optional Life

Each Child Amount of coverage _____

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

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

Optional AD&D

Plan member Amount of coverage _____

Spouse Amount of coverage _____

Each Child Amount of coverage _____

Spouse's signature _____

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 or 11.

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

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	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)**

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	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

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

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

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.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	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.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	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.

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 Nomination of trustee/administrator for minor beneficiary for Quebec residents

In Quebec, if you wish to designate minor children as beneficiaries, an administrator may be designated. A trustee may also be designated but a trust must then be set up more formally in accordance with the Civil Code of Quebec. A lawyer or notary should then be consulted. Unless specifics of a trust are provided, an appointment of trustee/administrator herein shall refer to an administrator according to the Civil Code of Quebec.

Any payments becoming due while the beneficiary is a minor* are to be made to _____ as trustee/administrator, or failing such trustee/administrator, to the minor child's tutor. Payment to the trustee/administrator or to the minor child's tutor will discharge the company.

* A minor is a child who has not reached the age of 18 years.

12 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 use and exchange 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 use and exchange 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, Optional Spouse Life and 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 my authorization in this section 12 is as valid as the original.

Plan member signature X	Date (yyyy/mm/dd)
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