Group benefits enrolment/change form

Sun Life Financial

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 last page 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	Email address	
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 ☐ Male ☐ Female	Date of birth (yyyy-mm-dd)

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 Beneficiary nomination

IMPORTANT:

Note: If you previously designated an irrevocable beneficiary, then the irrevocable beneficiary's consent is required for you to either: (a) replace the irrevocable beneficiary or (b) change the coverage amount or the percentage of benefits payable to the irrevocable beneficiary, resulting in a decreased allocation to the irrevocable beneficiary. Please have the irrevocable beneficiary complete and sign the Irrevocable beneficiary section below (section 7).

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.

If you are nominating a beneficiary who is a minor, please see section entitled *Nomination of trustee for minor beneficiary other than Quebec residents*.

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.

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

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

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

7 Irrevocable beneficiary consent (if applicable)

Only complete this section if you are an irrevocable beneficiary. If you were named as an irrevocable beneficiary, then the plan member requires your consent to: (a) replace you as beneficiary or (b) change the percentage of benefit payable to you upon the member's death.

Irrevocable beneficiary

Last name	First name

By signing below, I consent to the change of beneficiary as set out in this form. I hereby declare that I am of legal age.

Signature of beneficiary	Date signed (yyyy-mm-dd)
X	

8 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.

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

9 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) is 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.

10 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 declare that the information above is accurate and true. Inaccurate information may invalidate a claim.

I confirm that either (a) I did not previously appoint an irrevocable beneficiary under this group benefits plan issued by Sun Life or any other carrier; or, alternatively (b) I obtained the consent of the irrevocable beneficiary, who has completed the irrevocable beneficiary consent section (section 7), as required.

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	

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).