Sun Life Assurance Company of Canada

Additional Optional Life Enrollment Form (Effective January 1, 2004)

Sun Life Financial℠

1 Employer and Employee Information (Please print clearly)

Name of your employer	Policy number	Benefit group or class	Your annual basic earnings*
Contra Costa Community College District	**80816**		$

Your full legal name (first, middle initial, last)	Social Security Number	Date of birth	Date of hire	Your occupation
	| |			

2 Benefit Elections (Make your benefit elections below based on the coverage options described here)

Employee coverage: An amount between $25,000 and $400,000, in increments of $25,000, not to exceed five times your basic annual earnings.* Amounts available with no evidence of insurability required: None. **Age Reductions:** To 65% at age 70 and 50% at age 75. Benefits cease at retirement.

	I elect coverage	I decline coverage	Coverage amount selected
Employee coverage:	☐	☐	$

* Basic annual earnings do not include bonuses, commissions or overtime pay.

About Evidence of Insurability (also known as Proof of Good Health):

Evidence of Insurability (EOI) is needed if:

- You apply for coverage described in the Coverage Options above.
- You want to increase your existing coverage now (whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier).
- You want to increase your coverage at a later date.
- You decline coverage and then want it at a later date.

If EOI is needed, your coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

3 Acknowledgment and Signature (**Important:** You must read and sign for coverage)

I understand that:

- I am requesting Optional Life coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage now and want it at a later date, I will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the "About Evidence of Insurability" notice above.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Optional Life coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.

Signature of employee	Date signed
X	

Continued on Page 2

Sun Life Assurance Company of Canada

Evidence of Insurability Cover Page

Sun Life Financial℠

Employer Instructions

Complete this cover page and provide it to the employee. The employee may complete the Evidence of Insurability (EOI) application either online or on paper:

- **Online at www.sunlife-usa.com/planmembers**
  Our secure online system allows employees to provide all of the information needed for Evidence of Insurability in about 10 to 15 minutes. Following completion of the application, the employee receives confirmation by email. The employee then will receive notification of our decision by email or mail.
- **Printable EOI application**
  If submitting the EOI application on paper, the applicant must include this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

Employee/Dependent Information (To be completed by employer)

Employee Name (first, middle initial, last)		Group Policy Number
Social Security Number (last four digits) | | |	Approval Requested for	☐ Employee ☐ Spouse ☐ Dependent Child(ren): No. of Children:

Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverages for which EOI is required and fill in amounts. Need help? See the **Administrator's Guide** and your **Group Policy** on CustomerLink.

Life Insurance

	G.I. / Current Amount of Coverage	Requested Amount	Amount Subject to EOI
☐ Employee Basic	$	$	$
☐ Employee Optional	$	$	$
☐ Spouse Basic	$	$	$
☐ Spouse Optional	$	$	$
☐ Child Optional	$	$	$

Other Coverages

☐ Short Term Disability	
☐ Long Term Disability	
☐ Buy-Up LTD:	$

Employee Instructions

Complete and submit either the Online EOI Application or the Printable EOI Application, but <u>not both</u>.

- **Online EOI Application**
  1. Go to www.sunlife-usa.com/planmembers and click on Start under Evidence of Insurability
  2. Follow the instructions on the web site. Enter height weight, date of birth and medical history for you and any dependents on this application. Then, transfer the coverage type and amounts above to the Coverage Information section of the online application.
- **Printable EOI Application**
  1. Complete pages 1 and 2 of the EOI Application according to the instructions. You may type your answers into the fillable form and then print the document. Please remember to sign and date the form.
  2. Mail or Fax the EOI Application and this Employer Cover Page to us:

MAIL TO: Sun Life Assurance Company of Canada
Group Life Dept. SC 3227
One Sun Life Executive Park
P.O. Box 81100
Wellesley Hills, MA 02481

-or-

FAX TO: (781) 446-1517

Sun Life Assurance Company of Canada

Evidence of Insurability Application – Health Questionnaire

Sun Life Financial℠

I Applicant Information (Please print clearly)

Complete and return pages 1 and 2 of this form, along with the employer cover page to:

Sun Life Financial
Group Life Dept.
One Sun Life Exec. Park
P.O. Box 81100
Wellesley Hills, MA 02481

Fax: (781) 446-1517

Your name (first, middle initial, last)	Name of your employer	Group policy no.

Your street address	City	State	Zip Code

Social Security number – –	Daytime phone number	E-mail address

This Application is for: ☐ Employee ☐ Spouse ☐ Child ☐ Male ☐ Female

Name (if different than above)	Date of birth (m/d/y)	Height ft. in.	Weight lbs.

II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

Important: You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 2 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

1. In the past five years, have you:

a. Had transplant surgery, other surgery, injuries or been treated in a hospital? ☐ Yes ☐ No
b. Been treated for alcoholism or advised by a physician to change your drinking habits? ☐ Yes ☐ No
c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? ☐ Yes ☐ No
d. Been off work for more than five consecutive days due to illness or injury? ☐ Yes ☐ No
e. Lost 20 lbs. or more over a 12 month period? ☐ Yes ☐ No

2. In the past five years, have you been diagnosed with, treated for or had any symptoms relating to any of the conditions listed below?

a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder ☐ Yes ☐ No
b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder ☐ Yes ☐ No
c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack ☐ Yes ☐ No
d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs ☐ Yes ☐ No
e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder ☐ Yes ☐ No
f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus ☐ Yes ☐ No
g. Sugar in urine, diabetes, kidney or bladder disorder ☐ Yes ☐ No
h. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ☐ Yes ☐ No
i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder ☐ Yes ☐ No
j. Disorders of the eyes or ears ☐ Yes ☐ No
k. Chronic fatigue or fibromyalgia ☐ Yes ☐ No

3. Are you currently pregnant? ☐ Yes ☐ No

Domiciliary State – Michigan

Continued on next page

III Activities

Important: If you answer "Yes" to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

Do you engage in any of the following activities?

a. Skydiving ..... ☐ Yes ☐ No
b. Scuba diving ..... ☐ Yes ☐ No
c. Vehicle or boat racing ..... ☐ Yes ☐ No
d. Piloting an aircraft ..... ☐ Yes ☐ No

IV Detail (Provide detail below about any "Yes" answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you need more room, check here ☐ and attach a separate sheet.

V Signature

Please read the Certification and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

Certification

I hereby certify, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me the Fraud Warning for my state on Page 3.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- If I have any questions regarding my EOI Application, I can write to Sun Life Assurance Company of Canada, Group Life Dept., SC 3227, One Sun Life Executive Park, Wellesley Hills, MA 02481.

Signature of Employee X	Date signed
Signature of Spouse (If Application is for spouse) X	Date signed

Sun Life Assurance Company of Canada

Please read the applicable fraud warning before signing this form.

State Law requires us to notify you of the following:

Fraud Warning (for all states except those listed separately below): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning – Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning – Oklahoma: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning – Virginia and Washington: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

4 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event of your death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

☐ **Use my Basic Life beneficiaries** – Check this box and leave this section blank if you want your Optional Life Insurance beneficiaries to be the same as your Basic Life beneficiaries.

If you did not check the box above, make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Primary beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

Secondary (Contingent) beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

* The total within each class (Primary and Secondary) must equal 100%.

5 Calculating Your Cost (Find your monthly cost by adding all of the coverages you have selected)

Employee coverage:

1. Your monthly cost for Optional Life Insurance is based on how much coverage you select. Multiply the cost per $1,000 by your amount of coverage (divided by 1,000).

EMPLOYEE	
Age	**Monthly cost per $1,000 of coverage**
Under 25	$ 0.055
25 – 29	$ 0.066
30 – 34	$ 0.087
35 – 39	$ 0.098
40 – 44	$ 0.110
45 – 49	$ 0.164
50 – 54	$ 0.252
55 – 59	$ 0.471
60 – 64	$ 0.723
65 – 69	$ 1.391
70 +	$ 2.260

Employee: Make a copy of this form for your records before submitting it to your employer.
Employers: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another Optional Life Enrollment Form.