Sun Life Assurance Company of Canada

Group Enrollment Form Instructions

Eligible Employees

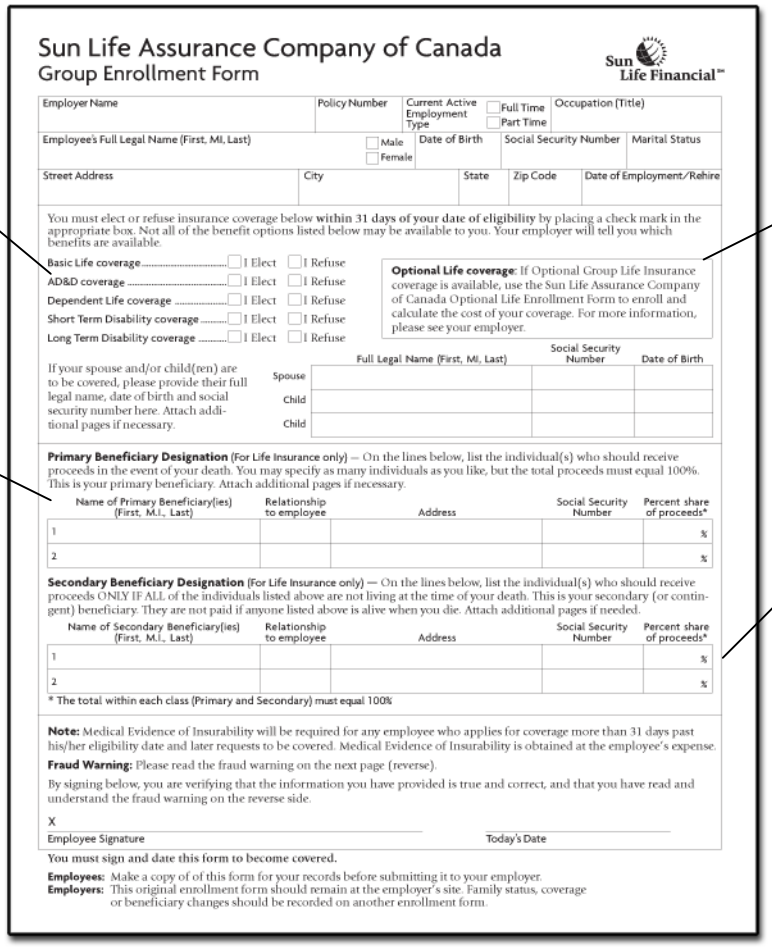
Complete all sections of the Group Enrollment form to enroll in the Group Policy, to reinstate your coverage or to refuse coverage. Make sure you complete and sign the form during the enrollment period or **within 31 days** of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

Sample Enrollment form

Check off either "I Elect" or "I Refuse" for each benefit offered by Sun Life Assurance Company of Canada through your Employer's plan.

Primary Beneficiary(ies): List the person or persons who should receive proceeds in the event of your death. You may list as many Primary Beneficiaries as you like, but the total proceeds must equal 100%. If you need more space, attach another sheet to this enrollment form.

If you do not designate a beneficiary, or if none of the beneficiaries you designated are living at the time of your death, proceeds will be payable to your estate.



Sun Life Assurance Company of Canada
Group Enrollment Form

Sun Life Financial℠

Employer Name	Policy Number	Current Active Employment Type	Occupation (Title)
		☐ Full Time ☐ Part Time	

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth	Social Security Number	Marital Status

Street Address	City	State	Zip Code	Date of Employment/Rehire

You must elect or refuse insurance coverage below **within 31 days of your date of eligibility** by placing a check mark in the appropriate box. Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available.

Basic Life coverage	☐ I Elect	☐ I Refuse
AD&D coverage	☐ I Elect	☐ I Refuse
Dependent Life coverage	☐ I Elect	☐ I Refuse
Short Term Disability coverage	☐ I Elect	☐ I Refuse
Long Term Disability coverage	☐ I Elect	☐ I Refuse

Optional Life coverage: If Optional Group Life Insurance coverage is available, use the Sun Life Assurance Company of Canada Optional Life Enrollment Form to enroll and calculate the cost of your coverage. For more information, please see your employer.

If your spouse and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number here. Attach additional pages if necessary.

	Full Legal Name (First, MI, Last)	Social Security Number	Date of Birth
Spouse			
Child			
Child			

Primary Beneficiary Designation (For Life Insurance only) — 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.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1				%
2				%

Secondary Beneficiary Designation (For Life Insurance only) — On the lines below, list the individual(s) who should receive 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. They are not paid if anyone listed above is alive when you die. Attach additional pages if needed.

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

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

Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

Fraud Warning: Please read the fraud warning on the next page (reverse).

By signing below, you are verifying that the information you have provided is true and correct, and that you have read and understand the fraud warning on the reverse side.

X _____ _____
Employee Signature Today's Date

You must sign and date this form to become covered.

Employees: 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 enrollment form.

Optional Life Insurance is elected using a separate Sun Life Assurance Company of Canada form. See your Employer for details.

Secondary Beneficiary(ies): List the person or persons who should receive the proceeds ONLY IF every person listed under Primary Beneficiaries is not living at the time of your death. You may list as many Secondary Beneficiaries as you like, but the total proceeds must equal 100%.

Sun Life Assurance Company of Canada
Group Enrollment Form

Employer Name	Policy Number	Current Active Employment Type	Occupation (Title)
Contra Costa Community College District		☐ Full Time ☐ Part Time	

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth	Social Security Number	Marital Status

Street Address	City	State	Zip Code	Date of Employment/Rehire

You must elect or refuse insurance coverage below **within 31 days of your date of eligibility** by placing a check mark in the appropriate box. Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available.

Basic Life coverage	☐ I Elect	☐ I Refuse
AD&D coverage	☐ I Elect	☐ I Refuse
Dependent Life coverage	☐ I Elect	☐ I Refuse
Short Term Disability coverage	☐ I Elect	☐ I Refuse
Long Term Disability coverage	☐ I Elect	☐ I Refuse

Optional Life coverage: If Optional Group Life Insurance coverage is available, use the Sun Life Assurance Company of Canada Optional Life Enrollment Form to enroll and calculate the cost of your coverage. For more information, please see your employer.

If your spouse and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number here. Attach additional pages if necessary.

	Full Legal Name (First, MI, Last)	Social Security Number	Date of Birth
Spouse			
Child			
Child			

Primary Beneficiary Designation (For Life Insurance only) — 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.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1				%
2				%

Secondary Beneficiary Designation (For Life Insurance only) — On the lines below, list the individual(s) who should receive 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. They are not paid if anyone listed above is alive when you die. Attach additional pages if needed.

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

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

Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

Fraud Warning: Please read the fraud warning on the next page (reverse).

By signing below, you are verifying that the information you have provided is true and correct, and that you have read and understand the fraud warning on the reverse side.

X _____ _____

Employee Signature | Today's Date

You must sign and date this form to become covered.

Employees: Make a copy of 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 enrollment form.

For Employer Use Only

Location	Plan (Group of Benefits)	Social Security No./Member ID

Provide the employee's earnings amount below. Most employers should use the "All Coverages" box only. However, if your group policy requires that you calculate separate earnings amounts by coverage, please enter those amounts in the second set of boxes.

Indicate whether earnings amount is annual pay, or some other pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

All Coverage Earnings $	☐ Annually ☐ Monthly	☐ Semi-monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____
Life Earnings $	☐ Annually ☐ Monthly	☐ Semi-monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____
STD Earnings $	☐ Annually ☐ Monthly	☐ Semi-monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____
LTD Earnings $	☐ Annually ☐ Monthly	☐ Semi-monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____

Fraud Warnings: Please read the fraud warning below before signing the Enrollment Form. State law requires that we notify you of the following:

Fraud Warning: 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 for residents of 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 for residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning for residents of Louisiana and Massachusetts: 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 for residents of Maryland: 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 as determined by a court of competent jurisdiction.

Fraud Warning for residents of 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 for residents of 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 for residents of Oregon, 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.