

Group benefits enrolment form for plans with Optional Life



Instructions

- The Plan administrator completes Section 1.
- Complete all the remaining sections and return the form to your plan administrator.

1 Information to be completed by plan administrator

Contract number		Contract holder 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"/> Monthly <input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly (Hrs./Wk. (please specify)) <input type="checkbox"/> Other

2 Plan member details

Important: To be eligible for Extended Health Benefits under this plan, you must have coverage through your Provincial Medicare plan (e.g. OHIP, RAMQ, MSP) or federal plan.

Plan member's last name	Middle initial	First name	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"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Coverage selection <input type="checkbox"/> Single <input type="checkbox"/> Family
If you are a resident of BC, AB or MB please provide your Pharmacare number			
Email address (Makes signing into <i>mysunlife.ca</i> to manage your benefits & claims easy)			

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

If you have a spouse, complete the following section.

IMPORTANT: A spouse must first claim from his/her own employer's plan.

To be eligible for Extended Health Benefits under this plan, your spouse must have coverage through their Provincial Medicare plan (e.g. OHIP, RAMQ, MSP) or federal plan.

Spouse's last name	Spouse's first name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (yyyy-mm-dd)
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If your spouse is a resident of BC, AB or MB, please provide their Pharmacare number

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 ☐ Family ☐ Single

Dental Care ☐ Family ☐ Single

Name of benefits carrier: _____

5 Children details

If you have dependent children, complete the following section.

IMPORTANT: Claims for covered children must be sent first to the plan of the parent whose birth date falls earlier in the year.

Child's last name	Child's first name	Date of birth (yyyy-mm-dd)	Gender	Student*	Over-age disabled child**
			<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 last name	Child's first name	Date of birth (yyyy-mm-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 last name	Child's first name	Date of birth (yyyy-mm-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 last name	Child's first name	Date of birth (yyyy-mm-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 dependent on you for financial support.

** To enrol an over-age disabled child, complete a Disabled Child Coverage form, and send it to us within 6 months of the date the dependent reaches the age limit.

(For Quebec plan members, please check with your plan administrator for dependent student age limit.)

6 Optional Life and Accidental Death and Dismemberment (AD&D) benefits

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 information in the right hand column if you are electing this coverage.

Optional Life

☐ Plan member

☐ Spouse (Spouse must complete and sign)

Amount of coverage \$	Amount of coverage \$
Have you used tobacco products within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you used tobacco products within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse's date of birth (yyyy-mm-dd)
	I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.
	Spouse's signature X _____

6 Optional Life and Accidental Death and Dismemberment (AD&D) benefits (continued)

Child Optional Life

☐ Each child

Amount of coverage

\$

Optional AD&D

☐ Plan member

☐ Spouse

Amount of coverage

\$

Amount of coverage

\$

☐ Each child

Amount of coverage

\$

7 Beneficiary nomination

IMPORTANT:

Note: If you want to make any of the beneficiaries you list below permanent, write 'irrevocable' beside their name. For example, this may be required as part of a separation agreement or a court order.

If you designate an irrevocable beneficiary, then the irrevocable beneficiary's consent is required for you to either: (a) replace the irrevocable beneficiary or (b) decrease the coverage amount or the percentage of benefits payable to the irrevocable beneficiary. Please have the irrevocable beneficiary complete, sign and date the Consent by Beneficiary form.

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

If you are nominating a beneficiary who is a minor under the age of 18, please see section entitled *Nomination of trustee for minor beneficiary*.

Complete each section for any benefits for which you have coverage.

Be sure to write the beneficiary's first and last name, as well as the relationship to you. The total allocation between your beneficiaries must equal 100%.

You must initial any changes or deletions. Correction fluid cannot be used.

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

Beneficiary for **Employee OPTIONAL 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

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.

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 %

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.

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

10 Nomination of trustee for minor beneficiary other than Quebec residents

If you wish to designate minor children under the age of 18 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 under the age of 18 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.

11 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 understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Optional Employee Life 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 signed form is valid. The original is still required for beneficiary nominations.

Plan member signature X	Date (yyyy-mm-dd)
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12 Respecting your privacy

Respecting your privacy is a priority for the Sun Life 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).