Sun Life Insurance and Annuity Company of New York

Group Enrollment Form – Basic Life and AD&D only

Sun Life Financial℠
Sun Life Insurance and Annuity Company of New York

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

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

GROUP INSURANCE COVERAGE

Your coverage includes **Basic Life** and **Accidental Death and Dismemberment (AD&D)** insurance.

These benefits are completely paid by 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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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

Use the boxes below to calculate the employee's earnings. His/her earnings may need to be calculated differently for different benefits. Please refer to your Group Policy for proper earnings definitions.

Life Earnings							☐ Hourly	☐ Monthly
$ _____	+	$ _____	+	$ _____	=	$ 0.00	☐ Weekly	☐ Semi-monthly
Base Earnings		Commissions (if applicable)		Bonus (if applicable)		Total Earnings	☐ Bi-Weekly	☐ Annually
Other Earnings							☐ Hourly	☐ Monthly
$ _____	+	$ _____	+	$ _____	=	$ 0.00	☐ Weekly	☐ Semi-monthly
Base Earnings		Commissions (if applicable)		Bonus (if applicable)		Total Earnings	☐ Bi-Weekly	☐ Annually

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