Sun Life Financial

☐ **Enrolment Form**
(Complete all sections)

☐ **New** ☐ **Re-Hire**
Date of Hire/Re-Hire (DD/MM/YYYY)____________________

☐ **Change Form**
(Complete shaded areas and any changes)

☐ **Beneficiary** ☐ **Dependent Status** ☐ **Termination**
☐ **Salary/Wages** ☐ **Other (please specify)** ________________
Date of Change (DD/MM/YYYY)____________________

1. EMPLOYEE DETAILS

Contract No: **Account No:** **Employee ID No:**

Company Name:

Last Name: **First Name:**

Address
Number Street City Province Postal Code

Marital Status: ☐ Single ☐ Common Law ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Date of Birth: (dd/mm/yyyy) | Sex: ☐ M ☐ F | Date of Permanent Full Time: (dd/mm/yyyy)

Dependents: ☐ Yes ☐ No | Occupation: | Province:

Annual Earnings: | Class: | Effective Date: (dd/mm/yyyy)

2. SPOUSE DETAILS

* U	Effective Date (dd/mm/yyyy)	Last Name	First Name	Sex	Date of Birth (dd/mm/yyyy)

If your spouse is covered for Extended Health Care and/or Dental benefits by his/her employer's plan, please indicate the coverage:

Dental ☐ None ☐ Single ☐ Family
Extended Health Care ☐ None ☐ Single ☐ Family

3. CHILDREN

* U	Effective Date (dd/mm/yyyy)	Last	First Name	Sex	Date of Birth (dd/mm/yyyy)	Student (Y/N)

*** U (UPDATE)** A = Addition C = Change T = Termination

NOTE: Canadian Life & Health Insurance Association (CLHIA) regulations state:

1. A spouse must first claim from his/her own employer's plan.
2. Covered children must first claim from the plan covering the parent with the earlier date of birth in the year. If both parents were born in the same month, the earlier day is used.

(Please see reverse side)

REFUSAL(S) IF YOU DO NOT CHOOSE COORDINATION OF BENEFITS WITH THE SPOUSAL PLAN.

Individuals must be insured for all benefits for which they are eligible under this policy, except that individuals who are insured for Extended Health Care or Dental benefits under this or another group policy may refuse such benefits. Refused benefits may be obtained without evidence of health at a later date if they are applied for within 31 days of the loss of the comparable benefits, otherwise evidence of health is required and insurance could be restricted or declined.

I refuse insurance on myself and dependents under ☐ Extended Health Care ☐ Dental

I refuse insurance on dependents under ☐ Extended Health Care ☐ Dental

If refusing benefits you must provide the policy no. ______________________ and the name of present insurer ______________________ in order to refuse coordination of benefits coverage.

BENEFICIARY NOMINATION

(Note: Any changes to the beneficiary must be initialled by the employee)

BENEFICIARY'S FAMILY NAME, GIVE NAME	RELATIONSHIP TO EMPLOYEE

or the survivor of them (if more than one beneficiary named)

Note: Consult your own legal adviser if this form does not meet your requirements for designating a beneficiary.

Where Quebec Law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: ☐ *revocable*

If the Employee Identification Number is my Social Insurance Number, I authorize the use of such number for tax reporting identification and the administration of my benefit.

I certify that all information provided in this form is accurate and true.

I authorize the following to exchange information needed for underwriting, administration or paying claims: Sun Life Assurance Company of Canada, any person or organization who has relevant personal information about me including health professionals, institutions and insurers: and any person performing services for us.

Employee's Signature: ______________________ Date Signed: ______________________