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 ☐ 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

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.

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%.

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Sun Life Assurance Company of Canada
Group Enrollment Form

Employer Name	Policy Number	Current Active Employment Type		Occupation (Title)
George Fox University	12334		☐ Full Time ☐ Part Time	

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

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.

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Sun Life Assurance Company of Canada

Optional Life and AD&D Enrollment Form

1 Employer, Employee and Dependent Information (Please print clearly)

Name of your employer	Policy number	Benefit group or class	Your annual basic earnings*
George Fox University	12334	All Full Time Employees	$

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

Your spouse's name (first, middle initial, last)**	Social Security Number	Date of birth	Date of marriage

Name(s) of child(ren) to be covered (attach additional pages if needed)**	Date(s) of birth

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

For yourself: An amount between $10,000 and $600,000, in increments of $10,000 not to exceed five times your basic annual earnings. Evidence of insurability required for amounts over $150,000. **Age Reductions:** To 65% at age 65 and to 50% at age 70. Benefits cease at retirement.

For your spouse: An amount between $10,000 and $250,000, in increments of $10,000. Evidence of insurability required for amounts over $50,000. Spouse coverage cannot exceed 100% of the employee's Optional Life coverage. Coverage ends when your spouse turns 70 years old.

For your eligible children: You can purchase an amount between $2,500 or $25,000 for each eligible child. For a description of children eligible for coverage, refer to your group insurance booklet or ask your employer.

	I elect coverage	I decline coverage	Coverage amount selected
Employee coverage:	☐	☐	$
Spouse coverage:**	☐	☐	$
Child(ren) coverage:**	☐	☐	$

* For most plans, "basic annual earnings" is defined as your salary. Basic annual earnings usually excludes bonuses, commissions or overtime. Please see your benefits booklet or check with your employer for the exact definition of earnings that applies to you.

** Your spouse and children may only be covered if you are.

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

I understand that:

- I am requesting Optional Life and AD&D 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 for me or my family now and want it at a later date, I/we will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the "About Evidence of Insurability" notice on page 2.
- 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.
- If my spouse or any of my dependent children are hospital-confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer hospital-confined and are able to perform their normal activities.

Signature of employee	Date signed
X	

Continued on Page 2

About Evidence of Insurability

Evidence of Insurability (EOI) is needed if:

- You apply for higher coverage than the limits 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) or 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.

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 and spouse coverage:

1. Find your/your spouse's age in the chart below and the corresponding cost.
2. Multiply the cost per $1,000 by your/your spouse's amount of coverage (divided by 1,000). Your cost will increase when you or your spouse moves into a new age band.

Child(ren) coverage:

1. Find the cost per $1,000 for child(ren) coverage in the chart below.
2. Multiply the cost per $1,000 by your child(ren)'s amount of coverage (divided by 1,000).

EMPLOYEE Age	EMPLOYEE Monthly cost per $1,000 of coverage**	SPOUSE Age	SPOUSE Monthly cost per $1,000 of coverage
Under 25	$ 0.08	Under 25	$ 0.05
25 – 29	$ 0.09	25 – 29	$ 0.06
30 – 34	$ 0.11	30 – 34	$ 0.08
35 – 39	$ 0.12	35 – 39	$ 0.09
40 – 44	$ 0.145	40 – 44	$ 0.115
45 – 49	$ 0.203	45 – 49	$ 0.173
50 – 54	$ 0.295	50 – 54	$ 0.265
55 – 59	$ 0.525	55 – 59	$ 0.495
60 – 64	$ 0.789	60 – 64	$ 0.759
65 – 69	$ 1.491	65 – 69	$ 1.461
70 – 74	$ 2.399		
74 +	$ 4.487		

CHILD(REN)	Monthly cost per $1,000 of coverage
All eligible children	$ 0.20

** Includes Optional AD&D

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.

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