Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)*
Attn: Group Eligibility WIN407
175 Addison Road
Windsor, CT 06095

ENROLLMENT REQUEST - VOLUNTARY LIFE

ANSWER ALL QUESTIONS COMPLETELY - PLEASE PRINT LEGIBLY

☐ **Add** ☐ **Change** ☐ **Termination** ☐ **Correction** **Date:** _____ **Reason:** _____

Group Account Number	Name of Employer	Billing Group	Pay Frequency

Employer's Address (Street, City, State, Zip)

Employee Last Name	Employee First Name	Middle Initial

Employee Address (Street, City, State, Zip)

Social Security Number / /	Gender ☐ Male ☐ Female	Date of Birth (Month, Day, Year)	☐ My employment is covered under a Union Collective Bargaining Agreement
Hours Worked per Week	Date of Hire (Month, Day, Year)	Salary ☐ Annual ☐ Monthly ☐ Weekly ☐ Hourly $ _____	Occupation/Title

Coverage For You

☐ I have used a tobacco product in the past 12 months ☐ I have not used a tobacco product in the past 12 months

☐ I elect to enroll in the Voluntary Life Plan for $ _____ (in $10,000 increments)
☐ I elect to enroll in the Voluntary Life and AD&D Plan for $ _____
OR
☐ For Salary Based Plans (please circle one): 1 2 3 4 5 Other _____ times your salary

☐ I decline the Voluntary Life Plan being offered to me at this time. I understand that if I decline coverage now and request coverage in the future the coverage may be limited or I will have to provide evidence of good health.
If you decline coverage for yourself, you also decline coverage for any dependent coverage being offered under the plan.

Note: Employees or spouses may elect an amount as outlined in the Group Voluntary Life Plan (check with your employer for the available non-medical issue amount). If you and/or your spouse apply for coverage in excess of the non-medical issue amount, you and/or your spouse will need to provide satisfactory evidence of insurability. Amount elected may be reduced due to age.

Beneficiary Designation

Primary Beneficiary

Last Name	First Name	Relationship to You

Address (Street, City, State, Zip)

Contingent Beneficiary

Last Name	First Name	Relationship to You

Address (Street, City, State, Zip)

Coverage For Your Spouse (Up to 50% of employee election)

☐ My spouse has used a tobacco product in the past 12 months ☐ My spouse has not used a tobacco product in the past 12 months

☐ I elect to enroll my spouse in the Voluntary Life Plan for $ _____ (in $5,000 increments)
☐ I elect to enroll my spouse in the Voluntary Life and AD&D Plan for $ _____

☐ I decline the Voluntary Life Plan being offered to my spouse at this time. I understand that if I decline coverage for my spouse now and request coverage in the future the coverage may be limited or my spouse will have to provide evidence of good health.

Coverage For Your Dependent Child(ren)

☐ I elect to enroll my child(ren) in the Voluntary Life Plan (including AD&D, if applicable) for $ _____

☐ I decline the Voluntary Life Plan (including AD&D, if applicable) being offered to my child(ren) at this time. I understand that if I decline coverage for my child(ren) now and request coverage in the future the coverage may be limited or my child(ren) will have to provide evidence of good health.

Please complete this *entire* section if you are selecting coverage for your spouse and/or dependent children.

Relationship	Last Name	First Name	M.I.	Date of Birth	Gender	Social Security Number
						/ /
						/ /
						/ /
						/ /

NOTE: YOU MUST SIGN THE BACK OF THIS FORM FOR THIS REQUEST TO BE VALID

You must read and sign this statement in order to request coverage through your employer

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any insurance for which I am or become eligible.

To the best of my knowledge and belief: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) the information shown is correct; (3) I understand that any incorrect statements may result in my coverage or my dependents' coverage being contested and/or claims not paid; (4) I have read this form; (5) I authorize SLHIC (U.S.) to verify all information; and (6) by having the insurance premium deducted from my salary or otherwise paying the premium for the insurance coverage selected on this Enrollment Request form, I authorize SLHIC (U.S.) to make and ratify any administrative corrections and/or additions identified in the "Home Office Corrections and/or Additions" section below. I understand that administrative corrections and/or additions do not include coverage election/refusal, coverage amounts or health information.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under the terms of this group coverage. I understand that all sums which may become due on account of my dependent's death under the terms of the dependent coverage, if included, will be payable to me.

To the best of my knowledge and belief I have read the warning on this form.

Signature of Employee **Date**

WARNING
STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:

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 (in Oregon, "may be guilty of insurance fraud,") commits a fraudulent insurance act, which (in Oregon, may be subject to prosecution.") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN 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."

IN LOUISIANA: "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."

IN 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."

IN NEW YORK: "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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. THIS NOTICE DOES NOT APPLY TO AN APPLICATION FOR LIFE INSURANCE".

IN PUERTO RICO: "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than $5,000 nor more than $10,000, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years. "

Home Office Corrections and/or Additions Only

*Formerly known as Genworth Life and Health Insurance Company. Sun Life and Health Insurance Company (U.S.) is a member of the Sun Life Financial group of companies.

Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)*
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

EVIDENCE OF INSURABILITY

ANSWER ALL QUESTIONS COMPLETELY - PLEASE PRINT LEGIBLY

Name of Employee (Last, First, M.I.)	Social Security Number	Employee's Occupation (Title)	Group Policy Number

Residence (No., Street, City, State, Zip Code)

Gender ☐ Male ☐ Female	Date of Birth (Mo., Day, Yr.)	Home Phone Number	Work Phone Number	E-Mail Address

Name of Firm	Firm Address (No., Street, City, State, Zip Code)

Reason for Evidence of Insurability ☐ Late Applicant ☐ Late Dependent Coverage ☐ Adding New Dependent
☐ Amount over Non-Med Issue ☐ Salary Increase/New Salary _____ per _____

HEALTH STATEMENT – Must be completed in its entirety.

The questions that follow must be answered for each employee and dependent requesting coverage. Failure to provide complete responses may result in underwriting delays, rescission of coverage and/or non-payment of claims. This request for coverage is not effective until approved by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)). No information provided by you to your agent shall bind SLHIC (U.S.) unless you also provide such information in writing on this form. No agent or broker has the authority to alter the contents of this form.

	YES	NO	Please answer questions 1-9 for you and all your dependents: For the past 10 years.
1.	☐	☐	Have you or any dependents ever had or been told that you/they had elevated blood pressure, chest pain, heart murmur, circulatory or other heart disorder; blood, pus or sugar in the urine, diabetes, kidney, liver or bladder disorder, OB/GYN disorder including diagnosis of or treatment for infertility, any sexually transmitted disease or disorder excluding the Human Immunodeficiency Virus (HIV), blood disorder, immunological disease or disorder excluding HIV, cancer or tumor, ulcer or other gastrointestinal disorder, disorder of the neck, back or knees, epilepsy or severe headache, asthma or respiratory disorder, mental, emotional or nervous disorder or alcoholism?
2.	☐	☐	Have you or any dependent ever been diagnosed or treated for AIDS-related complex (ARC) or acquired immune deficiency syndrome (AIDS)?
3.	☐	☐	Have you or any dependents experienced unexplained persistent diarrhea, unexplained unintentional weight loss, night sweats or persistent swollen glands?
4.	☐	☐	Have you or any dependents been hospitalized, had surgery, taken medication regularly or at frequent intervals or been treated by a physical or psychological health care practitioner for anything other than preventive care?
5.	☐	☐	Have you or any dependents ever been told you/they had chemical dependency, substance use, abuse and/or dependency, ever used narcotics, barbiturates, amphetamines, hallucinogens, or other drugs except as prescribed by a physician?
6.	☐	☐	Are you or any of your dependents currently pregnant? If yes, give due date _____
7.	☐	☐	Have you or any dependents used any type of tobacco products in the past 36 months?
8.	☐	☐	Have you or any dependents ever been told or had reason to believe that medical, surgical, psychiatric or rehabilitative care may be required during the next 12 months?
9.			Employee: Height: _____ Weight: _____ Spouse Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____ Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____ Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____ Dependent Name: _____ Date of Birth: _____ SS#: _____ Height: _____ Weight: _____

Give Details Below for All Questions Answered "Yes." (Use additional sheet if necessary)

Question No.	Name of Person Treated	Nature of Ailment	Date of Onset, Duration and Degree of Recovery	Name and Address of Physician, Practitioner, Hospital or Institution

If there is a history of elevated blood pressure complete the following:

☐ History applies to Employee

List 3 Current Blood Pressure Readings Measured at 5-10 Minute Intervals ① ② ③	Date of Readings	Any Medication? ☐ Yes ☐ No	If "Yes" Name and Dosage

☐ History applies to Spouse

List 3 Current Blood Pressure Readings Measured at 5-10 Minute Intervals ① ② ③	Date of Readings	Any Medication? ☐ Yes ☐ No	If "Yes" Name and Dosage

Please make sure you read and sign the back of this form.

Authorization to Obtain and Disclose Protected Health Information

To the best of my knowledge all information shown above is correct and I have read this form.

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, insurance or reinsurance company, to disclose or furnish to **Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.))** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to **records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, Acquired Immune Deficiency Syndrome (AIDS)** or information relating to alcohol or drug abuse if a specific authorization form for release of this information is obtained or mental health care to the extent permitted by law.

I authorize SLHIC (U.S.) to use or disclose this protected health information, in connection with payment or health care operations, to the Health Claim Index (HCI), any reinsurer, and any person or entity performing a business or legal function on behalf of SLHIC (U.S.) or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a request for insurance coverage; (2) my refusal to sign this authorization may result in an application being denied; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date
Signature of Spouse	Date

Access to Personal Information

Personal information may be collected from persons other than the individual or individuals proposed for coverage. Such information as well as other personal or privileged information subsequently collected by the insured institution or agent may in certain circumstances be disclosed to third parties without authorization. You have the right to see your personal records and correct personal information collected. You will be furnished with our detailed Description of Information Practices form (GNW-GL1607) upon request from either the firm administrator and/or the Home Office.

California Notice

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraudulent Insurance Act – WARNING

WARNING
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