

# Sun Life Insurance and Annuity Company of New York Group Short Term Disability Enrollment Form



Employer Name	Policy Number	Current Active Employment Type <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Occupation (Title)
Employee's Full Legal Name (First, MI, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
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.

**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.

Short Term Disability coverage     I Elect     I Refuse

**Fraud Warning:** Please read the following fraud warning below before signing the Enrollment form. State law requires that we notify you of the following:

Any person who knowingly and with intent to defraud any insurance company or any 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 above.

X

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Today's Date

**You must sign and date this form to become covered.**

## For Employer Use Only

Location	Social Security No./Member ID
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Provide the employee's earnings amount below. 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.

STD Earnings \$	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Weekly	<input type="checkbox"/> Hourly
	<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly	Number of hours worked per week: _____

**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.