

Group benefits enrolment/change form for plans with Optional Life



Instructions

- Section 1 is to be completed by the plan administrator.
- All remaining sections are to be completed by the plan member.
- Complete the form in ink, sign and date the form.
- Please PRINT clearly.

1 Information to be completed by plan administrator

- Enrolment Form**
(Complete all sections)
- Change Form**
(Only complete the information that is changing and include the effective date of change).
- Beneficiary** **Dependent Status** **Termination** **Salary/Wages**
- Other** (please specify) _____

Contract Number 043413		Contractholder name SECA	
<input type="checkbox"/> New plan member <input type="checkbox"/> Re-hire	Date of hire/re-hire (yyyy/mmm/dd)	Plan member ID	Class/Plan
Effective date of coverage/change (yyyy/mmm/dd)	Location/billing group number	Location/billing group name	
Occupation	Salary \$	Basis <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly (Hrs./Wk. _____) <input type="checkbox"/> Other _____ (please specify)

2 Plan member details

Plan member's name (first, middle initial, last)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (street number and name, apartment or suite)			
City	Province	Postal Code	
Date of birth (yyyy/mmm/dd)	Language <input type="checkbox"/> English <input type="checkbox"/> French	Province of residence	Province of employment
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	Civil Union <input type="checkbox"/> Civil Union Coverage selection <input type="checkbox"/> Single <input type="checkbox"/> Family

3 Refusal of benefits

If you or your dependents are presently covered for Extended Health Care and/or Dental Care benefits under another group contract you may refuse to be covered for such benefit(s) under this contract by selecting the applicable box for each benefit:

I refuse coverage for myself and my dependents under: **Extended Health Care** **Dental Care**

I refuse coverage for my dependents under: **Extended Health Care** **Dental Care**

4 Spouse details

Complete this section only if you are applying for coverage for your spouse.

***U** (Update codes):

A = Addition

C = Change

T = Termination

*U	Effective date (yyyy/mmm/dd)	Spouse's name (first, last)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (yyyy/mmm/dd)
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If your spouse is covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan, please indicate spouse's coverage:

Dental None Single Family

Extended Health Care None Single Family Name of Benefits Carrier: _____

5 Children details

Complete this section only if you are applying for coverage for your children.

IMPORTANT:

1. A spouse must first claim from his/her own employer's plan.
2. Claims for covered children must be sent first to the plan of the parent whose birth date falls earlier in the year.

				Gender	Student*	Overage disabled child**
*U	Effective date (yyyy/mmm/dd)	Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*U	Effective date (yyyy/mmm/dd)	Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*U	Effective date (yyyy/mmm/dd)	Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*U	Effective date (yyyy/mmm/dd)	Child's name (first, last)	Date of birth (yyyy/mmm/dd)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

* A student is a child age 21 or over but under age 25, who is a full-time student attending an educational institution recognized by Canada Revenue Agency, as long as the child is not married or in any other formal union and is entirely dependent on you for financial support.
(For Quebec Plan members please check with your plan administrator for dependent student age limit.)

** To enrol an overage disabled child, complete a Handicapped Child Coverage Form, and send it to us within 31 days of the date the dependent reaches the age limit.

6 Optional Life and Accidental Death and Dismemberment benefits (AD&D)

Your plan administrator will advise you which of these benefits are offered under your plan and how much coverage you can select.

Complete only for the optional benefits that you are electing or changing. Your spouse must complete and sign the Spouse Optional Life information in the right hand column if you are electing this coverage.

Optional Life

Plan member

Add Change Amount of coverage _____
Terminate

Have you used tobacco products within the past 12 months? Yes No

Child Optional Life

Each Child

Add Change Amount of coverage _____
Terminate

Optional AD&D

Plan member

Add Change Amount of coverage _____
Terminate

Spouse

Add Change Amount of coverage _____
Terminate

Each Child

Add Change Amount of coverage _____
Terminate

Spouse (Spouse must complete and sign)

Add Change Amount of coverage _____
Terminate

Have you used tobacco products within the past 12 months? Yes No

Spouse's birth date _____
(yyyy/mmm/dd)

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

Spouse's signature _____

7 Beneficiary nomination

IMPORTANT:

Complete each section for any benefits for which you are applying.

Be sure to show the beneficiary's first and last name, as well as the relationship to you.

You must initial any changes or deletions. Correction fluid cannot be used.

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.

If you are nominating a beneficiary who is a minor, please see section 10.

By completing this section I revoke all previously nominated beneficiary nominations and make the following nomination where permitted by law.

Beneficiary for **Employee BASIC Life and Accidental Death Benefits (if applicable)**

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: <input type="checkbox"/> Revocable		

Beneficiary for **Employee OPTIONAL Life and Accidental Death Benefits (if applicable)**

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here: <input type="checkbox"/> Revocable		

8 Spouse beneficiary nomination (to be completed by the plan member)

Complete this section if you are applying for spouse optional coverage.

By completing this section I revoke all previously nominated beneficiary nominations and make the following nomination where permitted by law.

Beneficiary for **Spouse OPTIONAL Life and Accidental Death Benefits (if applicable)**

You may nominate yourself or someone other than your spouse as the beneficiary.

If no beneficiary is nominated, you are automatically the beneficiary.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage

9 Appointing contingent beneficiaries

If you wish to appoint a contingent beneficiary, in the event that there are no surviving beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Unless I specify otherwise, my contingent beneficiary will apply to all my benefits.

I revoke all previous contingent beneficiary appointments.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage

10 Trustee nomination for minor beneficiary

If you wish to designate minor children as beneficiaries, a Trustee/Administrator must be designated. In Quebec, "Trustee" shall be understood as "Administrator", and the obligations of the Administrator shall be interpreted in accordance with the Quebec Civil Code.

Any payments becoming due while the beneficiary(s) are a minor*, are to be made to _____ as trustee, or failing such trustee to the duly appointed guardian of such minor child as trustee. Payment to the trustee will discharge the company.

* A minor is a child who has not reached the age of majority as defined by provincial legislation.

11 Authorization and signature

IMPORTANT:
You must sign and date the form.

I am authorized to disclose information about my spouse and dependents in order to enrol them in the Plan.

By enrolling in this Plan, I authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims,
- My plan sponsor, and its agents to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required,
- Sun Life Assurance Company of Canada, its agents and service providers, and my plan sponsor and its agents to use and exchange information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I understand that satisfactory proof of good health may be required for myself or my spouse to become covered or to increase Optional Employee or Optional Spouse Life coverage.

I declare that the information above is accurate and true. Inaccurate information may invalidate my claim.

A photocopy or electronic version of this authorization is as valid as the original.

Plan member signature X	Date (yyyy/mmm/dd)
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Sun Life Assurance Company of Canada a member of the Sun Life Financial group of companies is committed to keeping your information confidential.