

Sun Life Financial

Group Enrollment form



Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

1 General information

Employer name Colorado Higher Education Insurance Benefits Alliance Trust - Metropolitan State University of Denver		Account/policy number 935916	Location	Date effective
Street address		City	State	Zip code
Type of activity: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason:			Occupation	

2 Employee information

Employee's Full Legal Name (First, MI, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Street Address		City	State	Zip Code
Marital Status	Social Security Number		Phone number	
Date employed: <input type="checkbox"/> Full-Time Date: <input type="checkbox"/> Part-Time Date: <input type="checkbox"/> Rehire <input type="checkbox"/> Return from layoff Date:				
Current Active Employment Type _____ # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Employee Status: <input type="checkbox"/> Management <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired		Salary

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is. See the Evidence of Insurability section for details.

3 Benefit elections

Voluntary AD&D coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

	Elect	Refuse	Coverage amount elected
Employee coverage:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Spouse coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Child(ren) coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	\$

** Spouse and Children may only be covered if you are.

4 Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security number	Date of birth	Check if elected				
					Dep Life	Dep Dental	Dep Vol AD&D	[Critical Illness] [Cancer]	Accident
Spouse / Partner					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5 Beneficiary Designation information

Voluntary AD&D Insurance – 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. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

Percent share of proceeds*

1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

* Must equal 100%]

Voluntary AD&D Insurance— On the lines below, list the individual(s) who should receive the 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. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)			Percent share of proceeds*
1 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	
2 Name (First, M.I., Last)	Relationship to employee	Social Security number	%
Address	Phone number	Date of birth	

* Must equal 100%]]

6 Authorization information

I understand that:

- I am requesting 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 premium for contributory coverage from my pay.
- If I decline coverage for Voluntary AD&D and do not enroll when I am eligible, I will not be allowed to enroll for at least 6 months.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, 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 confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

X

Employee Signature

Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment form.

Contact us



By mail

Sun Life Financial
One Sun Life Executive Park
Wellesley Hills, MA 02481



www.sunlife.com/us



Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET

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