

# Sun Life

One Sun Life Executive Park, Wellesley Hills, MA 02481



## Group Enrollment Form

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

Employer use (check one):  New employee  Change  COBRA

### 1. General Information

Employer Name	Account / Policy Number	Location
City of Ripon	948387	

### 2. Employee Information

<b>Employee's Full Legal Name (First, M.I., Last)</b>		<input type="checkbox"/> Male	<b>Date of Birth</b>	
		<input type="checkbox"/> Female		
<b>Street Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Occupation</b>		<b>Eligibility Class (if applicable)</b>	<b>Social Security Number</b>	<b>Phone Number</b>
<b>Date employed:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		<b>Date:</b> <input type="checkbox"/> Return from layoff <input type="checkbox"/> Rehire	<b>Date:</b>	
<b>Current Active Employment Type</b> <input type="checkbox"/> # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		<b>Earnings \$</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____		

### 3. 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, M.I., Last)	Gender	Social Security number	Date of birth	Student Y/N
Spouse					
Children					

#### 4. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below 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.

Elect	Refuse	Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Dental: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
Were you covered under another dental plan within the last 31 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," provide the termination date: _____		
Reason for termination of coverage? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Vision: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family

#### 5. Signature and 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, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant benefit waiting period specified in the certificate of insurance.
- For Dental Insurance plans, I have the right to select any dental care provider of my choice.
- The dental plan includes a pre-determination provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- Coverages include benefit waiting periods, limitations and exclusions that may affect my entitlement to benefits.
- 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, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage may not start until the date they are no longer confined and are able to perform their normal activities.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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

I confirm by signing below that I have minimal essential coverage (major medical coverage).

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.

Agent, Broker, and/or Enroller information:

Agent name
Agent / Broker name
Enroller name

**Contact us**



**By mail**

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[www.sunlife.com/us](http://www.sunlife.com/us)



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

