



ENROLLMENT REQUEST

Add Change Termination Correction
Date: Reason:

Employer Information - to be completed by Employer

1. Group Account Number 2. Other Group Account Number(s) 3. Class Network Billing Group
4. Name of Employer
5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This entire section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.) 7. Social Security Number
8. Employee's Address (Number, Street, City, State, ZIP Code) 9. Employee's Home Phone No.
10. Sex 11. Date of Birth (Mo., Day, Yr.) 12. Marital Status 13. My employment is covered under Union Collective Bargaining
14. Hours worked weekly for this employer 15. Date Employed (Mo., Day, Yr.)
16. Basic Earnings 17. Employee's Occupation (Title)

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Life/AD&D Dental Dependent Life/AD&D Medical Dependent Medical Supplemental Life/AD&D Weekly Indemnity/STD Long Term Disability
I Elect I Refuse I Elect I Refuse I Elect I Refuse I Elect I Refuse I Elect I Refuse I Elect I Refuse

*If you have refused Medical or Dental, is it because you have other Group Coverage?
Medical Yes No Dental Yes No

**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage?
Medical Yes No Dental Yes No

Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage? Yes If so, Single Family Dependent(s)
Individual Policy Group Policy HMO Other
Name of Carrier Termination date of Coverage
Reason for Termination

Please complete this entire section if you are selecting Medical and/or Dental Coverage.

Table with 7 columns: Relationship, Last Name, First Name, M.I., Date of Birth, Sex, Social Security Number. Includes Employee row.

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: School Name and Address:
Course of Study: Semester: Anticipated Date of Graduation (month/year):

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

22. Primary - Last Name First Name & Middle Initial Relationship Address
23. Contingent - Last Name First Name & Middle Initial Relationship Address

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

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

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge and belief and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment may result in my coverage being contested subject to the incontestability provision and that all statements made by me shall be deemed to be representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge and belief I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

24. Date

25. Signature

WARNING

Disability income benefits may be reduced by other sources of income. Read your certificate carefully.

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 (in North Carolina, "may subject") subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

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 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 knowingly files a statement of claim containing any false or misleading information 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 concerning 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."

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

In Georgia, any person who signs this Enrollment Form acknowledges notification of the following:

1. You are entitled to a list of providers participating in our PPO network. Provider Directories are available by contacting our Group Policyholder Services Department at 800-451-2513 or by viewing our website at <https://ebg.sunlife.com>.
2. You are entitled to receive treatment from a provider of your choosing. You will receive a higher level of benefits for medical services when choosing a PPO physician or hospital.
3. There are no limited utilization incentive plans for providers of medical services. The provider is not given an incentive or bonus that encourages withholding services or influences referral to specialists.

You will be provided with a Disclosure form after the effective date of your Group Policy. This Disclosure will provide details of the above.

*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.