Sun Life Financial
Group Enrollment form for Retirees and Survivors

Sun Life Financial®

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

1 General information

Employer name	Account/policy number	Location	Date effective
Town of Weymouth	5484911		

Street address	City	State	Zip code
75 MIDDLE STREET	**WEYMOUTH**	**MA**	**02189**

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation **(Retiree/Survivor TOWN or MTRS)**

2 Retiree/Survivor information

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth

Street Address	City	State	Zip Code

Marital Status	Social Security Number	Phone number

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Current Active Employment Type	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary
_____ # of hours ☐ Full-Time ☐ Part-Time		

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

Dental coverage: Underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

If you refuse 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 plan certificate of coverage.
For more information, please contact your employer.

Dental ☐ Elect ..... ☐ Cancel/Terminate
☐ Employee
☐ Family

Plan Option: ☐ Basic
☐ Enhanced
☐ [illegible]

The certificate provides dental benefits only. Review your certificate carefully.

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 Dental
Spouse / Partner					☐
Children					☐
					☐
					☐

5 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 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.