Group benefits enrolment form

Sun Life Financial

Keeping your information confidential

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers and reinsurers who, in some instances, may be located in jurisdictions outside Canada. Your personal information may be subject to the laws of those foreign jurisdictions. Sun Life Financial's operations worldwide and our third-party providers are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

Instructions

- Section 1 is to be completed by the plan administrator.
- All remaining sections are to be completed by the plan member and returned to your plan administrator.

Please PRINT clearly. Complete the form in ink, sign and date the form on page 3 and return to your plan administrator for handling.

1 Information to be completed by plan administrator

Contract number	Class/Plan	Plan member ID	☐ New plan member ☐ Re-hire	Date of hire/re-hire (yyyy-mm-dd) 2015 – 01 – 01
Location/billing group number	Location/billing group name	Contract holder name: Sharon Health Counseling Ltd		
Effective date of coverage (yyyy-mm-dd) 2021 – 01 – 01	Occupation: president	Salary $ [redacted] Basis ☒ Annual ☐ Monthly ☐ Bi-weekly ☐ Semi-monthly ☐ Weekly ☐ Hourly (Hrs./Wk. ____) ☐ Other ____ (please specify)		

2 Plan member details

Plan member's last name	Middle initial	First name	Gender ☒ Male ☐ Female	Language ☒ English ☐ French
[redacted]		[redacted]		

Address (street number and name)	Apartment or suite	City
[redacted]		Vancouver

Province	Postal code	Date of birth (yyyy-mm-dd)	Email address
BC	V6J4J2	[redacted]	[redacted]

Province of residence	Province of employment	Marital status	Coverage selection
BC	BC	☐ Single ☒ Married ☐ Common Law ☐ Civil Union ☐ Divorced ☐ Separated ☐ Widowed	☐ Single ☒ 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 Banking details

If you wish to have your Extended Health Care and/or Dental Care benefit payments deposited directly into your bank account, attach a void cheque, direct deposit form or bank verification statement.

If you do not have a chequing account, you must provide a direct deposit form or bank verification statement from your bank branch. This form must be provided by your bank, trust company, caisse populaire or credit union in Canada, and be signed and stamped by a banking representative. If your bank provides an online direct deposit form, pre-populated with your banking information, this can also be submitted. These forms must contain your name, the Bank Number, your Branch Number and Account Number to facilitate your benefit payment being deposited directly into your account.

Please attach a void cheque, direct deposit form or bank verification statement

5 Spouse details – *complete this section only if you are applying for coverage for your spouse*

Spouse's last name	Spouse's first name	Gender	Date of birth (yyyy-mm-dd)
[redacted]	[redacted]	☐ Male ☒ Female	[redacted]

Is your spouse covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?

☒ No ☐ Yes If *yes*, please indicate spouse's coverage:

Extended Health Care ☐ Family ☐ Single **Dental Care** ☐ Family ☐ Single

Name of benefits carrier: _____

6 Children details – *complete this section only if you are applying for coverage for your children*

Child's last name	Child's first name	Date of birth (yyyy-mm-dd)	Gender	Student*	Over-age disabled child**
[redacted]	[redacted]	[redacted]	☐ Male ☒ Female	☒ Yes ☐ No	☐ Yes ☒ No
		_ _	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
		_ _	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
		_ _	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ 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 over-age disabled child, complete a Disabled Child Coverage form, and send it to us within 31 days of the date the dependent reaches the age limit.

7 Beneficiary nomination

Beneficiary for **Employee BASIC Life** and **Accidental Death Benefits (if applicable)**
You must initial any changes or deletions. Correction fluid cannot be used.

Last name	First name	Relationship to plan member	Percentage
[redacted]	[redacted]	spouse	100.00 %
			%
			%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

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 do not nominate a beneficiary, the proceeds will be paid to your estate.

If you are nominating a beneficiary who is a minor, please see section 9.

8 Appointing contingent beneficiaries – *please complete this section if you wish to appoint a contingent beneficiary*

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.

Last name	First name	Relationship to plan member	Percentage
			%
			%
			%

In Quebec, if you name your legal spouse (married or civil union) as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box. ☐ Revocable beneficiary

9 Nomination of trustee for minor beneficiary other than Quebec residents

If you wish to designate minor children as beneficiaries, a trustee must be designated.

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.

NOTE: In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf.

10 Authorization and signature – *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 and its reinsurers to collect, use and disclose relevant information about me to underwrite, administer, adjudicate and deposit claim payments,
- My plan sponsor 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 and my plan sponsor to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and for the purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

A photocopy or electronic version of this authorization is as valid as the original. A photocopy or electronic version of this form is not valid for recording beneficiary nominations.

Plan member signature	Date (yyyy-mm-dd)
X [redacted]	2020 – 12 – 19