Sun Life Insurance and Annuity Company of New York

60 East 42nd Street, Suite 3100, New York, NY 10165

Group Enrollment Form

Sun Life Financial®
Sun Life Insurance and Annuity Company of New York

Complete all sections of the Group Enrollment Form. Make sure you complete and sign the form during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

Employer name	Policy number	Current active employment type	Occupation (Title)
JPW RIGGERS, INC.	*819001*	☐ Full-Time ☐ Part-Time	

Employee's full legal name (First, M.I., Last)	☐ Male ☐ Female	Date of birth	Social Security number	Marital status

Street address	City	State	Zip code	Date of employment/rehire

You must elect or refuse insurance coverage below within 31 days of your date of eligibility by placing a check mark in the appropriate box. Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available.

Basic Life coverage.....X Elect ☐ Refuse
AD&D coverage.....X Elect ☐ Refuse
Dependent Life coverage ....☐ Elect X Refuse
Short Term Disability coverage .....☐ Elect X Refuse
Long Term Disability.....☐ Elect X Refuse

Optional Life coverage: If Optional Group Life Insurance coverage is available, use the Sun Life Insurance and Annuity Company of New York Optional Life Enrollment Form to enroll and calculate the cost of your coverage. For more information, please see your employer.

If your spouse and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number here. Attach additional pages if necessary.

	Full Legal Name (First, M.I., Last)	Social Security Number	Date of Birth
Spouse			
Child			
Child			

Primary Beneficiary Designation (For Life Insurance Only) -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

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1				%
2				

Secondary Beneficiary Designation (For Life Insurance Only) - 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. They are not paid if anyone listed above is alive when you die. Attach additional pages if necessary.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship to employee	Address	Social Security Number	Percent share of proceeds*
1			XXX-XX-	%
2			XXX-XX-	%

* The total within each class (Primary and Secondary must equal 100%

NOTE: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

Fraud Warning: Not applicable to Life Insurance. Please read the fraud warning below.

Accelerated Benefits: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. If you have received an accelerated benefit, your life insurance will be reduced by an amount equal to the accelerated benefit paid by Sun Life (N.Y.).

You must sign and date this form to be covered. By signing below, you are verifying that the information you have provided is true and correct, and that you have read and understand the fraud warning below.

X _____ _____

Employee Signature Today's Date

This enrollment form is attached to and made part of the group policy.

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.

For Employer Use Only

Provide the employee's earnings amount below. Most employers should use the "All Coverages" box only. However, if your group policy requires that you calculate separate earnings amounts by coverage, please enter those amounts in the second set of boxes.

Indicate whether earnings amount is annual pay, or some other pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

All Coverage Earnings $	☐ Annual ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly	☐ Hourly Number of hours worked per week: _____

Life Earnings $	☐ Annual ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly	☐ Hourly Number of hours worked per week: _____
STD Earnings $	☐ Annual ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly	☐ Hourly Number of hours worked per week: _____
LTD Earnings $	☐ Annual ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly	☐ Hourly Number of hours worked per week: _____

Fraud Warnings (Not applicable to Life Insurance):

Please read the fraud warning below before signing the Enrollment Form. State law requires that we notify you of the following:

Fraud Warning: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.