Group benefits enrolment form

Sun Life

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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.
- Complete the form in ink, sign and date the form.
- Please PRINT clearly.

Plan Member ID

1 Information to be completed by plan administrator

Contract number	Contractholder name	
55134	**The Free Methodist Church in Canada**	
☐ New plan member ☐ Re-hire	Date of hire/re-hire (yyyy/mmm/dd)	Class/Plan
Effective date of coverage (yyyy/mmm/dd)	Location/billing group number	Location/billing group name
Occupation	Salary $	Basis ☐ Annual ☐ Monthly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Weekly ☐ Hourly (Hrs./Wk. ____) ☐ Other ____ (please specify)

2 Plan member details

Plan member's name (first, middle initial, last)			Gender ☐ Male ☐ Female
Address (street number and name, apartment or suite)			
City		Province	Postal code
Date of birth (yyyy/mmm/dd)	Language ☐ English ☐ French	Province of residence	Province of employment
Marital status ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Common Law ☐ Widowed ☐ Civil Union			Coverage selection ☐ 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** and **Dental Care**

☐ I refuse coverage for my dependents under **Extended Health Care** and **Dental Care**

4 Spouse details

Complete this section only if you are applying for coverage for your spouse.

Spouse's name (first, last)	Gender ☐ Male ☐ Female	Date of birth (yyyy/mmm/dd)

Is your spouse covered for Extended Health Care and/or Dental Care benefits by his/her employer's plan?
☐ Yes ☐ No If *Yes*, please indicate spouse's coverage:

Dental Care ☐ Family ☐ Single

Extended Health Care ☐ Family ☐ Single Name of Benefits Carrier: _____

5 Children details

Complete this section only if you are applying for coverage for your children.

IMPORTANT:

1. A spouse must first claim from his/her own employer's plan.
2. Claims for covered children must be sent first to the plan of the parent whose birth date falls earlier in the year.

Child's name (first, last)	Date of birth (yyyy/mmm/dd)	Gender	Student*	Overage disabled child**
		☐ 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 overage disabled child, complete a Handicapped Child Coverage Form, and send it to us within 31 days of the date the dependent reaches the age limit.

6 Beneficiary nomination

IMPORTANT:
Be sure to show the beneficiary's first and last name, as well as the relationship to you.

You must initial any changes or deletions. Correction fluid cannot be used.

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.

Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	Relationship to plan member	Percentage
Name (first, last)	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		

7 Authorization and signature

IMPORTANT:
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, its agents and service providers, its reinsurers and their service providers to use and exchange relevant information about me to underwrite, administer and adjudicate claims,
- My plan sponsor, and its agents 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, its agents and service providers, and my plan sponsor and its agents to use and exchange 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 my authorization in this section 7 is as valid as the original.

Plan member signature	Date (yyyy/mmm/dd)
X	