50,000

Sun Life Assurance Company of Canada
Group Enrollment Form – Basic Life and AD&D Only

Employer name MSD of Decatur Township		100-3733	Current active employment type	☐x Full-Time ☐ Part-Time	Occupation (Title) Certified
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	

GROUP INSURANCE COVERAGE

Your coverage includes **Basic Life** and

Accidental Death and Dismemberment (AD&D) insurance.

These benefits are completely paid by your employer.

Dependent Life (if available) - 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	NA	NA	NA
Child	NA	NA	NA
Child	NA	NA	NA

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			XXX-XX-	%
2			XXX-XX-	%

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: Please read the fraud warning on page 2.

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 on page 2.

X

Employee Signature Today's Date

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.