Sun Life and Health Insurance Company (U.S.)

One Sun Life Executive Park, Wellesley Hills, MA 02481 800-247-6875
Group Enrollment form for Employee Basic Life and AD&D Insurance

Sun Life Financial®

1. General Information

Employer Name	**Account / Policy Number**	**Location**	**Date Effective**
Harrison Association Teachers Benefit Trust Fund	911183	Bldg/District Admin	
Street Address	**City**	**State**	**Zip Code**
c/o Preferred Group, Inc. P.O. Box 15136	Albany	NY	12212-5136
Type of activity: ☐ New Enrollment ☐ Change Reason:		**Occupation** Teachers - HAT	

2. Employee Information

Employee's Full Legal Name (First, M.I., 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 Date:	☐ Return from layoff Date:
Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	**Employee Status:** ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired		**Salary**

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from the insurance company above, inside 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. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

3. Beneficiary Designation Information

Primary Beneficiary Designation

Employee Basic Life and AD&D Insurance - 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. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance certificate.

Primary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

Secondary Beneficiary Designation

Employee Basic Life and AD&D Insurance - On the lines below, list the individual(s) who should receive proceeds ONLY IF ALL of the primary beneficiaries listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

1. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

2. Name (First, M.I., Last)	Relationship to employee	Social Security Number	Percent share of proceeds* %
Address	Phone number	Date of birth	

*Must equal 100%

- The total within each class (Primary and Secondary) must equal 100%. If you do not name a beneficiary or if no beneficiaries are alive at the time of your death, proceeds will be payable in accordance with your Group insurance certificate.

4. 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.

I have read or had read to me the fraud warning for my state.

Does not apply to Life Insurance. 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.

Signature of employee X	Date signed

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.

Contact us

By mail
Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET