

Sun Life Assurance Company of Canada

Life and AD&D Enrollment Form

1. Employer, Employee and Dependent Information (Please print clearly)					
Name of your employer Loyola University New Orleans	Policy Number 90429	Benefit group or class All Full Time Employees		Your basic annual earnings* \$	
Your full legal name (first, middle initial, last)	Social Security Number	Date of birth	Date of hire	Your occupation	
Your spouse's name (first, middle initial, last) **	Social Security Number	Date of birth	Date of marriage		
Name(s) of child(ren) to be covered (attach additional pages if needed)**			Date(s) of birth		

2. Benefit Elections (make your benefit elections below based on the coverage options described here)

I request the following insurance coverage elections:

Basic Term Life and AD&D Insurance

Life and AD&D Insurance of One Times Base Annual Earnings *- University Paid (no election needed)

Additional Basic Life and AD&D Insurance of One Times Base Annual Earnings

Basic Dependent Term Life: \$5,000 for spouse; \$5,000 each child (\$1,500 for children 14 days to 1 year)

Total Basic & Additional Basic Life Insurance Maximum up to \$250,000.00.

or

or

No coverage

No coverage

Optional Term Life Insurance

Check one for employee coverages: No coverage 1 x basic annual earnings 2 x basic annual earnings 3 x basic annual earnings

Maximum benefit of \$500,000 Amounts over \$250,000 require evidence of insurability

Check one for spouse coverages: No coverage 50% of employee amount up to \$50,000.

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Amounts over \$20,000 require evidence of insurability.

Optional Accidental Death and Dismemberment (AD&D)

Check one: No coverage Employee Plan Employee and Family Plan

Select Coverage Amount 1x 2x 3x 4x 5x 6x 7x 8x 9x 10x

(multiple of basic annual pay)

Maximum benefit of \$500,000

* Basic annual earnings do not include supplemental pay, including stipends, grants or overtime pay.

** Your dependents may only be covered if you are covered. Optional term life for your spouse ends when he or she reaches age 70.

Reductions in term life benefits apply at age 70 (university basic & additional basic term life up to maximum benefit of \$25000.00, optional term life 1x-3x salary up to maximum benefit of \$25000.00).

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About Evidence of Insurability (also known as Proof of Good Health):

Evidence of Insurability (EOI) for term life coverage elections is needed if:

- You apply for higher coverage than the limits described in the Coverage Options.
- You want to increase your existing coverage now (whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier).
- You want to increase your coverage at a later date.
- You decline coverage and then want it at a later date.

IF EOI is needed, your coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

3. Acknowledgement and Signature (Important: You must read and sign for coverage)

I understand that:

- I am requesting Optional Life 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 premiums from my pay.
- If I decline coverage for me or my spouse now and want it at a later date, I/we will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the “About Evidence of Insurability” notice above.
- 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 subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Optional Life coverage is scheduled to start under the plan, such coverages will not start until the date I return to work.
- If my spouse is hospital-confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date he/she is no longer hospital-confined and is able to perform their normal activities.

Signature of employee X	Date signed
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4. Beneficiary Designation

Designation Of Beneficiary For Employee Life Benefits
(The Dependent Life Benefits are Payable to the Employee. Proceeds for other losses, such as accidental dismemberment or accidental death of a covered family member, will be paid to the Employee.)

I Designate as my Primary Beneficiary: My Designation of Beneficiary is on a separate form which is signed, dated and attached.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
TOTAL:				100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies)

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
TOTAL:				100%

Unless designated otherwise, payment will be made in equal shares or all to the survivor.

I RESERVE the right to change this designation at any time.

Signature of employee X	Date signed
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Employee: Make a copy of this form for your records before submitting it to your employer. This original enrollment form should remain at the employer’s site. Family Status, coverage, or beneficiary changes should be on another Enrollment Form.