

ENROLLMENT REQUEST-VOLUNTARY DENTAL

ANSWER ALL QUESTIONS COMPLETELY - PLEASE PRINT LEGIBLY

Add
 Change
 Termination
 Correction
 Date: _____ Reason: _____

Group Account Number	Name of Employer	Billing Group	Pay Frequency
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Employer's Address (Street, City, State, Zip)

Employee Last Name	Employee First Name	Middle Initial
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Employee Address (Street, City, State, Zip)

Social Security Number / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month, Day, Year)	<input type="checkbox"/> My employment is covered under a Union Collective Bargaining Agreement
Hours Worked per Week	Date of Hire (Month, Day, Year)	Salary <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly \$ _____	Occupation/Title

NOTE: Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE DECLINED. All benefits may not be available; check with your plan administrator.

Group Benefits Requested - to be completed by Employee. Please select one of the following:

- Employee Only I elect
- Employee and Spouse I elect
- Employee and Child(ren) I elect
- Family (Employee, Spouse, and Child) I elect

Decline All Voluntary Dental Benefits
 I decline dental benefits for myself, which automatically declines dental benefits for my dependents. I understand that if I decline coverage now and later request to add the benefit, my coverage may be limited as outlined in the plan certificate of coverage.

Please complete this *entire* section if you are selecting coverage for spouse and/or dependent(s).

Relationship	Last Name	First Name	M.I.	Date of Birth	Gender	Social Security Number
						/ /
						/ /
						/ /
						/ /
						/ /

Student Verification - Please complete the following if any child listed is a full-time student at an accredited college or university. Please attach a separate sheet if you have more than one child enrolled in college full-time.

Name of child: _____ School Name, City and State: _____

Course of Study: _____ Semester: _____ Anticipated date of graduation (month/year): _____

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any insurance for which I am or become eligible.

I certify that: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) the information shown is correct; (3) I understand that any incorrect statements may result in my coverage or my dependents' coverage being terminated, rescinded and/or claims not paid; (4) I have read this form; (5) I authorize SLHIC (U.S.) to verify all information; and (6) by having the insurance premium deducted from my salary or otherwise paying the premium for the insurance coverage selected on this Enrollment Request form, I authorize SLHIC (U.S.) to make and ratify any administrative corrections and/or additions identified in the "Home Office Corrections and/or Additions" section below. I understand that administrative corrections and/or additions do not include coverage election/refusal, coverage amounts or health information.

I understand the coverage made available to me and I wish to enroll (or decline to enroll) in this coverage as indicated above. I understand that if I do not enroll in this coverage now, but later decide to enroll, I must wait until the next designated open enrollment period.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given by him are binding upon me. I also agree that my participation in the benefits(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the warning on the reverse side of this form.

 Signature of Employee _____
 Date

Georgia Notice

IN GEORGIA: Any person who signs this Enrollment Form acknowledges notification of the following:

1. You are entitled to a list of providers participating in our PPO network. Provider Directories are available by contacting our Group Customer Service at 800-451-2513 or by viewing our website at <https://ebg.sunlife.com>.
2. You are entitled to receive treatment from a provider of your choosing. You will receive a higher level of benefits for medical services when choosing a PPO physician or hospital.
3. There are no limited utilization incentive plans for providers of medical services. The provider is not given an incentive or bonus that encourages withholding services or influences referral to specialists.

WARNING

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:

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 (in Oregon, "may be guilty of insurance fraud,") commits a fraudulent insurance act, which (in Oregon, may be subject to prosecution.) is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN FLORIDA: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

IN LOUISIANA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

IN NEW JERSEY: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

IN NEW YORK: "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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

IN PUERTO RICO: "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than \$5,000 nor more than \$10,000, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years. "

Home Office Corrections and/or Additions Only

