



Insurance/Beneficiary Change Form

Please complete this form to change your voluntary/optional insurance benefits and/or to change your nominated beneficiary(ies). PLEASE PRINT CLEARLY.

1. MEMBER DETAILS (to be completed by Member/Employee)

<u>Contract No.</u> Life: 57880, Critical Illness: 105118, AD&D: 100006183, VAD&D: 100006184		<u>Contract Holder Name</u> COVENANT HEALTH	<u>Site</u>	<u>Payroll No.</u>
<u>Effective date of coverage</u> (yyyy/mmm/dd)		<u>Location/Billing Group No.</u> 001/A	<u>Class/Plan</u> EXEMPT	
<u>Name on File</u> (first, middle initial, last)			<u>New Name</u> (first, middle initial, last) - if applicable	
<u>Current Address</u> (street number and name, apartment or suite)				
<u>City</u>	<u>Province</u>	<u>Postal Code</u>		
<u>Date of Birth</u> (yyyy/mmm/dd)				
<u>Occupation</u>				
<u>Marital Status</u> <input type="checkbox"/> Single <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law				

2. BENEFITS YOU ELECT TO CHANGE ARE (check all that apply)

<input type="checkbox"/> <u>Voluntary/Optional Life Insurance</u> (A Medical Health Statement must be completed to add or increase coverage for employee and/or spouse. Sun Life must receive your application and review for approval prior to enrollment. Please obtain this form from your Benefits Representative.)	
<input type="checkbox"/> ADD coverage <input type="checkbox"/> REMOVE coverage <input type="checkbox"/> CHANGE current coverage	
If ADDING or CHANGING, please indicate amount/type of coverage applied for:	
<input type="checkbox"/> Employee:	Amount of Coverage: \$ _____ (available in units of \$10,000 to a maximum of \$500,000)
<input type="checkbox"/> Spouse:	Date of Birth (yyyy/mmm/dd): _____ Amount of Coverage: \$ _____ (available in units of \$10,000 to a maximum of \$500,000) Please Select: <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker Please Select: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Child:	Amount of Coverage: \$ _____ (available in units of \$5,000 to a maximum of \$25,000)

Optional Critical Illness Insurance

(A Medical Health Statement must be completed to add or increase coverage for employee and/or spouse. Sun Life must receive your application and review for approval prior to enrollment. Please obtain this form from your Benefits Representative.)

- ADD coverage**
- REMOVE coverage**
- CHANGE current coverage**

If **ADDING** or **CHANGING**, please indicate amount/type of coverage applied for:

- Employee: **Amount of Coverage:** \$ _____
(available in units of \$10,000 to a maximum of \$250,000)
Please Select: Non-Smoker Smoker
- Spouse: **Date of Birth (yyyy/mmm/dd):** _____
Amount of Coverage: \$ _____
(available in units of \$10,000 to a maximum of \$250,000)
Please Select: Non-Smoker Smoker
Please Select: Male Female

Voluntary Accidental Death & Dismemberment Insurance:

- ADD coverage**
- REMOVE coverage**
- CHANGE current coverage**

If **ADDING** or **CHANGING**, please indicate amount/type of coverage applied for:

- Single \$0.315 / \$10,000 coverage
- Family \$0.450 / \$10,000 coverage
- Amount of Coverage:** \$ _____
(available in units of \$10,000 to a maximum of \$350,000)

3. BENEFICIARY NOMINATION (to be completed by Member/Employee)

For: Mandatory Basic Life and Accidental Death & Dismemberment Insurance Benefits

Name (first, last)	Relationship to Member	Percentage

Total must equal 100%

For: Voluntary/Optional Basic Life and Accidental Death & Dismemberment Insurance Benefits

- Same as above; OR

Name (first, last)	Relationship to Member	Percentage

Total must equal 100%

Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here:

Revocable

Please note that according to legal requirements, Sun Life Assurance Company of Canada cannot pay benefits to beneficiaries who are minors. A Trustee for minor children must be designated, except in Quebec.

Beneficiary Trustee Nomination

Any payments becoming due during the minority of the minor(s) are to be made to

_____ as Trustee, or failing such Trustee to the duty appointed guardian of
(first name, middle initial, last name)

such minor child as Trustee. Trustee's relationship to employee: _____

Payment to said Trustee shall discharge the company.

4. AUTHORIZATION AND SIGNATURE (to be completed by Member/Employee)

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 pay claims.
- My plan sponsor to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required.

I understand that satisfactory proof of good health may be required from me to become covered or to increase coverage. I declare the information above is accurate and true. Inaccurate information may invalidate my claim. A photocopy or electronic version of this authorization is as valid as the original.

Member Signature	Date (yyyy/mmm/dd)
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Sun Life Assurance Company of Canada, a member of Sun Life Financial group of companies, is committed to keeping your information confidential.