Sun Life Insurance and Annuity Company of New York and Sun Life and Health Insurance Company (U.S.) in New York

Group Enrollment Form for Voluntary STD

☐ Sun Life Insurance and Annuity Company of New York
60 East 42nd Street, Suite 3100
New York, NY 10165

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

Complete all sections of the Group Enrollment Form. Make sure you complete and sign the form during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer (also called non-contributory benefits) cannot be refused.

General Information

Employer name	Account/Policy number	Location	Date effective
The Research Foundation of State University of New York	811737		

Street address	City	State	Zip code

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Employee Information

Employee's Full Legal Name (First, MI, Last) ☐ Male ☐ Female	Date of Birth	Marital Status	Social Security No.

Street Address	City	State	Zip Code

Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee Status: ☐ Regular salaried Employees working 50% of a full-time schedule earning at least $15,000 annually ☐ Active ☐ Exempt ☐ Non-exempt	Salary

You must elect or refuse insurance coverage below within 31 days of your date of eligibility by placing a check mark in the appropriate box(es). Not all of the benefit options listed below may be available to you. Your employer will tell you which benefits are available and what your Maximum Guarantee Issue amount is. See "Evidence of Insurability" section for details.

Disability coverage: Underwritten by Sun Life Insurance and Annuity Company of New York (New York, NY)

Voluntary Short Term Disability ☐ Elect..... ☐ Refuse

Coverage amount selected _____*

*Amount is limited to 60% of the Basic Weekly Earnings

Evidence of Insurability:
A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Insurance and Annuity Company of New York or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage subject to evidence of insurability will not go into effect until Sun Life Insurance and Annuity Company of New York approves it.

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 decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Insurance and Annuity Company of New York. I have read the Evidence of Insurability notice.
- I have read the following Fraud Warning below.
  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
- 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 verifying that the information I have provided is true and correct to the best of my knowledge and belief.

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.