Sun Life Assurance Company of Canada
Group Enrollment Form

Employer Name	Policy Number	Effective Date	Occupation (Title)
City of Somerville	902386		

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth	Annual Salary	# of Pay Periods

Please elect or refuse coverage below one time by placing a check mark in the appropriate box. All employees must be actively at work and not on any leave of absence to enroll in the program.

Long Term Disability Plan ☐ I Elect ☐ I Refuse

Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

By signing below, you are verifying that the information you have provided is true and correct.

X

Employee Signature

Today's Date

You must sign and date this form to become covered.

Employees: Make a copy of of this form for your records before submitting it to your employer.
Employers: This original enrollment form should remain at the employer's site. Family status, coverage or beneficiary changes should be recorded on another enrollment form.