

EMPLOYEE CHANGE REQUEST

Name of Firm	Firm's State	Account Number 1	Account Number 2
Name of Employee		Social Security Number	Date of Change

CHANGE OF COVERAGE

PLEASE NOTE: If you refuse any coverage now and at a later date request to add that coverage, you may have to furnish at your own expense, evidence of insurability satisfactory to Sun Life and Health Insurance Company (U.S.) for each person to be covered.

ELECTION OF COVERAGE / REFUSAL OF COVERAGE

I ELECT	I REFUSE		I ELECT	I REFUSE	
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life			
<input type="checkbox"/>	<input type="checkbox"/>	Medical Coverage for Myself <input type="checkbox"/> PPO/Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Medical Coverage for My Eligible Dependents. Are any dependents still insured? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? _____
<input type="checkbox"/>	<input type="checkbox"/>	Dental Coverage for Myself <input type="checkbox"/> PPO/Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Dental Coverage for My Eligible Dependents. Are any dependents still insured? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? _____
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life Coverage	<input type="checkbox"/>	<input type="checkbox"/>	Dependent Life Coverage for My Eligible Dependents. Number of Dependents _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Indemnity	<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life - Please complete the appropriate enrollment and request form: XGR/2029			

Reason _____ . If due to marriage or birth of a child, please supply date(s) _____

My current salary is \$ _____ per _____ (Basic earnings, excluding overtime)

Employee's Signature	Date Signed
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Did you or your Dependent have prior coverage? Yes No If "yes", Single Family Dependent

Individual Policy Group Policy HMO Other _____

Name of Carrier _____

Termination Date of Coverage ____ / ____ / ____ Reason for Termination _____

CLASS CHANGE/TRANSFER

Transfer From Account _____ to _____ Effective Date _____

Class Change From _____ to _____ Effective Date _____

Please Check Reasons:

New Occupation (State New Occupation) _____ Salary \$ _____

Retirement Other _____

When reporting Terminations, Salary Changes or Name Changes call toll free 800 451.2513 or complete the appropriate section(s) below.

TERMINATION

Last Day of Employment (MM/DD/YY)	Reason	Election of Continuance (Please attach form)
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SALARY CHANGE

Effective Date (MM/DD/YY)	Basic Earnings \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Hours Worked Per Week (Excluding overtime)
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NAME CHANGE

Date of Change	New Name	Previous Name	Reason	Date Received
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Address Change (Employee's Address, Number, Street, City, State, ZIP Code):

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. "

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.

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 Policyholder Services Department at 800-451-2513 or by viewing our website at <http://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.

You will be provided with a Disclosure form after the effective date of your Group Policy. This Disclosure will provide details of the above.

NOTICES CONCERNING MEDICAL COVERAGE:

PRE-EXISTING CONDITIONS (not applicable to pregnancy). The Medical Plan contains a pre-existing condition limitation that may apply to you and/or your dependents. Any applicable pre-existing condition limitation will be reduced by your prior creditable coverage, if any. You have the right to request a certificate of creditable coverage from your prior health plan and we will assist you in obtaining this certificate, if necessary. For additional information regarding the plan's pre-existing condition limitation, please see your plan administrator.

SPECIAL ENROLLMENT RIGHTS. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this medical plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption or placement for adoption.