

☐ Sun Life Assurance Company of Canada  
One Sun Life Executive Park  
Wellesley Hills, MA 02481

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

### 1. General Information

|                                                                                                          |                                          |                    |                       |
|----------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------|-----------------------|
| <b>Employer Name</b><br>MTC Holding Corporation                                                          | <b>Account / Policy Number</b><br>246671 | <b>Location</b>    | <b>Date Effective</b> |
| <b>Street Address</b>                                                                                    | <b>City</b>                              | <b>State</b><br>KS | <b>Zip Code</b>       |
| <b>Type of activity:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Reason: |                                          | <b>Occupation</b>  |                       |

### 2. Employee Information

|                                                                                                                           |                                             |                                                                                                                                                                                                                                   |                                                      |                 |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------|
| <b>Employee's Full Legal Name (First, M.I., Last)</b>                                                                     |                                             | <input type="checkbox"/> Male<br><input type="checkbox"/> Female                                                                                                                                                                  | <b>Date of Birth</b>                                 |                 |
| <b>Street Address</b>                                                                                                     |                                             | <b>City</b>                                                                                                                                                                                                                       | <b>State</b>                                         | <b>Zip Code</b> |
| <b>Marital Status</b>                                                                                                     | <b>Social Security Number</b>               |                                                                                                                                                                                                                                   | <b>Phone Number</b>                                  |                 |
| <b>Date employed:</b> <input type="checkbox"/> Full-Time<br>Date:                                                         | <input type="checkbox"/> Part-Time<br>Date: | <input type="checkbox"/> Rehire<br>Date:                                                                                                                                                                                          | <input type="checkbox"/> Return from layoff<br>Date: |                 |
| <b>Current Active Employment Type</b><br># of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time |                                             | <b>Employee Status:</b> <input type="checkbox"/> Management <input type="checkbox"/> Salary<br><input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Retired |                                                      | <b>Salary</b>   |

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

### 3. Benefit Elections

| Voluntary AD&D Coverage: underwritten by Sun Life Assurance Company of Canada (Wellesley, MA) |                          |                          |                         |  |
|-----------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------|--|
|                                                                                               | Elect                    | Refuse                   | Coverage amount elected |  |
| Employee Coverage:                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____                |  |
| Spouse Coverage: **                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____                |  |
| Child(ren) Coverage: **                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____                |  |

\*\* Spouse and children may only be covered if you are. You cannot elect more than 50% of the amount of Voluntary Insurance you have elected for yourself for your spouse and child(ren).

#### 4. Dependent Information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

| Relationship      | Full Legal Name<br>(First, Middle Initial, Last) | Gender | Social<br>Security No. | Date of Birth | Check if elected         |                          |
|-------------------|--------------------------------------------------|--------|------------------------|---------------|--------------------------|--------------------------|
|                   |                                                  |        |                        |               | Dep Life                 | Dep Vol AD&D             |
| Spouse or Partner |                                                  |        |                        |               | <input type="checkbox"/> | <input type="checkbox"/> |
| Children          |                                                  |        |                        |               | <input type="checkbox"/> | <input type="checkbox"/> |
|                   |                                                  |        |                        |               | <input type="checkbox"/> | <input type="checkbox"/> |
|                   |                                                  |        |                        |               | <input type="checkbox"/> | <input type="checkbox"/> |

#### 5. Beneficiary Designation Information

##### Primary Beneficiary Designation

**Voluntary AD&D Insurance** - On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

Primary Beneficiary(ies)

|                             |                          |                        |                                 |
|-----------------------------|--------------------------|------------------------|---------------------------------|
| 1. Name (First, M.I., Last) | Relationship to employee | Social Security Number | Percent share of proceeds*<br>% |
| Address                     | Phone number             | Date of birth          |                                 |
| 2. Name (First, M.I., Last) | Relationship to employee | Social Security Number | Percent share of proceeds*<br>% |
| Address                     | Phone number             | Date of birth          |                                 |

\*Must equal 100%

##### Secondary Beneficiary Designation

**Voluntary AD&D Insurance** - On the lines below, list the individual(s) who should receive proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if your primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

Secondary Beneficiary(ies)

|                             |                          |                        |                                 |
|-----------------------------|--------------------------|------------------------|---------------------------------|
| 1. Name (First, M.I., Last) | Relationship to employee | Social Security Number | Percent share of proceeds*<br>% |
| Address                     | Phone number             | Date of birth          |                                 |
| 2. Name (First, M.I., Last) | Relationship to employee | Social Security Number | Percent share of proceeds*<br>% |
| Address                     | Phone number             | Date of birth          |                                 |

\*Must equal 100%

## 6. Authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for Voluntary AD&D and do not enroll when I am eligible, I will not be allowed to enroll for at least 6 months.
- 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 representing that the information I have provided is true and correct to the best of my knowledge and belief.

|                            |             |
|----------------------------|-------------|
| Signature of employee<br>X | Date signed |
|----------------------------|-------------|

**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.

### Contact us



#### By mail

Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.)  
One Sun Life Executive Park  
Wellesley Hills, MA 02481



[www.sunlife.com/us](http://www.sunlife.com/us)



Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET

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# Sun Life Financial

One Sun Life Executive Park, Wellesley Hills, MA 02481



## Group Enrollment Form

☐ Sun Life Assurance Company of Canada  
One Sun Life Executive Park  
Wellesley Hills, MA 02481

Employer use (check one): ☐ New employee ☐ Change ☐ COBRA

### 1. General Information

|                                                 |                                          |                 |
|-------------------------------------------------|------------------------------------------|-----------------|
| <b>Employer Name</b><br>MTC Holding Corporation | <b>Account / Policy Number</b><br>246671 | <b>Location</b> |
|-------------------------------------------------|------------------------------------------|-----------------|

### 2. Employee Information

|                                                                                                                           |                                                                                                                                                                                                |                                                                             |                      |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------|
| <b>Employee's Full Legal Name (First, M.I., Last)</b>                                                                     |                                                                                                                                                                                                | <input type="checkbox"/> Male<br><input type="checkbox"/> Female            | <b>Date of Birth</b> |
| <b>Street Address</b>                                                                                                     | <b>City</b>                                                                                                                                                                                    | <b>State</b>                                                                | <b>Zip Code</b>      |
| <b>Occupation</b>                                                                                                         | <b>Eligibility Class (if applicable)</b>                                                                                                                                                       | <b>Social Security Number</b>                                               | <b>Phone Number</b>  |
| <b>Date employed:</b> <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time                               | Date: _____                                                                                                                                                                                    | <input type="checkbox"/> Return from layoff <input type="checkbox"/> Rehire | Date: _____          |
| <b>Current Active Employment Type</b><br># of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time | <b>Earnings \$</b><br><input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____ |                                                                             |                      |

### 3. Dependent Information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

| Relationship | Full legal name (First, M.I., Last) | Gender | Social Security number | Date of birth | Student Y / N |
|--------------|-------------------------------------|--------|------------------------|---------------|---------------|
| Spouse       |                                     |        |                        |               |               |
| Children     |                                     |        |                        |               |               |
|              |                                     |        |                        |               |               |
|              |                                     |        |                        |               |               |

### 4. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

| Elect                    | Refuse                   | Coverage                                  |
|--------------------------|--------------------------|-------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Employee Optional Life Insurance \$ _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Spouse Optional Life Insurance \$ _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Optional Life Insurance \$ _____    |

**Employer provided benefits**--Your employer pays the premiums for the following benefits if you are eligible for them. Enrollment is automatic; no election is required.

☒ Employee Basic Life and Accidental Death & Dismemberment (AD&D)

**5. Beneficiary Designation Information**

**Primary Beneficiary Designation**

On the lines below, list the individual(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total proceeds must equal 100%. This is your primary beneficiary. Attach additional pages if necessary. If you do not name a beneficiary or if no beneficiary is alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy. Designation applies to all coverages for which a beneficiary designation is required.

|                            |                          |                        |                            |
|----------------------------|--------------------------|------------------------|----------------------------|
| Primary Beneficiary(ies)   |                          |                        | Percent share of proceeds* |
| 1 Name (First, M.I., Last) | Relationship to employee | Social Security number | %                          |
| Address                    | Phone number             | Date of birth          |                            |
| 2 Name (First, M.I., Last) | Relationship to employee | Social Security number | %                          |
| Address                    | Phone number             | Date of birth          |                            |

\*Must equal 100%

**Secondary Beneficiary Designation**

On the lines below, list the individual(s) who should receive the proceeds ONLY IF ALL of the individuals listed above are not living at the time of your death. This is your secondary (or contingent) beneficiary. The Secondary beneficiary is not paid if a primary beneficiary is alive at the time of your death. Attach additional pages if necessary.

|                            |                          |                        |                            |
|----------------------------|--------------------------|------------------------|----------------------------|
| Secondary Beneficiary(ies) |                          |                        | Percent share of proceeds* |
| 1 Name (First, M.I., Last) | Relationship to employee | Social Security number | %                          |
| Address                    | Phone number             | Date of birth          |                            |
| 2 Name (First, M.I., Last) | Relationship to employee | Social Security number | %                          |
| Address                    | Phone number             | Date of birth          |                            |

\*Must equal 100%

## 6. Signature and authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If applying for coverage more than 31 days past my eligibility date, Evidence of Insurability (EOI) may be required.
- For Life insurance, Evidence of Insurability may be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Life benefits may require Evidence of Insurability.
- 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, if required for the elected coverage(s), to be approved by Sun Life Assurance Company of Canada (Wellesley, MA).
- Coverages include limitations and exclusions that may affect my entitlement to benefits.
- 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 representing 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.

Agent, Broker, and/or Enroller information:

|                     |
|---------------------|
| Agent name          |
| Agent / Broker name |
| Enroller name       |

### Contact us



#### By mail

Sun Life Financial  
One Sun Life Executive Park  
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[www.sunlife.com/us](http://www.sunlife.com/us)



Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET

