
E-Z CHOICE – ENROLLMENT REQUEST

To be used in the following states: IN, LA, MN, SD, VT, WA

Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) Submission Requirements:

- Completed E-Z Choice Enrollment Request form
- Initial deposit check equal to monthly premium amount (check must be written on a business account and may not be a starter check)
- Copy of current carrier's most recent billing statement
- Copy of current carrier's booklet for all LTD cases and all Dental cases requesting waivers
- Copy of sold proposal (including rate calculation sheet(s) if applicable) as presented to the employer

(If any of the above items are incomplete, case cannot be processed.)

If applicable...

- Notification of Waiver Form
- Evidence of Insurability Applications for benefits exceeding Non-Medical Issue Limits
- Quarterly State Wage Reports may be requested at the discretion of the Home Office.

Submission instructions...

- Submit all required materials to General Agent or Master General Agent, if applicable, or mail to:
Sun Life and Health Insurance Company (U.S.)
Employee Benefits Group
Attn: E-Z Choice Unit WIN 301
175 Addison Road.
Windsor, CT 06095
- New business submission material must be postmarked no later than five business days after the requested effective date. If later, the case effective date will be deferred to the following month.

POLICYHOLDER INFORMATION

Please complete in full where appropriate. Incomplete applications delay processing.

Policyholder's Legal Name _____ Employer's Tax ID# _____

Policyholder's Business Address _____

City _____ State _____ ZIP Code _____

Policyholder's Contact _____ Title _____
(person to contact concerning coverages)

Telephone (_____) _____

Fax (_____) _____ email address _____ Effective Date Requested ____/____/____

Number of Full Time Employees _____ Years in Business _____ SIC Code & Nature of Business _____

Please check appropriate box: Corporation Proprietorship Partnership Other _____

Is this an employer-sponsored insurance program? Yes No

Subsidiaries/Alternate Locations Indicate subsidiaries or other locations, affiliates, to be covered:

Name _____ Address _____
(No., Street, City, State ZIP Code)

Tax I.D. _____ SIC Code _____ Nature of Business _____

Is this employer presently insured with SLHIC (U.S.) or has this employer previously applied for or had coverage with SLHIC (U.S.)? Yes No

If yes, please indicate coverage(s) _____ Account # _____

Are you in the process of filing bankruptcy (Chapter 7), reorganization (Chapter 11) or similar insolvency proceedings? Yes No

If yes, please explain _____

Are there any applicants who are totally disabled? Yes No

If yes, please provide names here _____

Certificate – Please indicate certificate preference (check one): Electronic (Certificate will be e-mailed as an attachment) Paper Copies

Definition of Eligibility – Eligible employees must be working at the employer's usual place of business. Employees not regularly working at least 30 hours per week are considered part-time. (Foreign National employees are eligible for coverage while residing in the United States).

Eligibility includes: All full-time employees* Other (specify) _____

*Partnerships only – Eligibility includes Partners/Owners who are working full time for this employer. Yes No

The above definition of eligibility applies to: All Coverages or

Applies only to: Life/AD&D Dental STD LTD

Definition of Earnings (complete only for Life/AD&D, Short and/or Long Term Disability)

Option 1: (Standard)

Basic earnings **exclude overtime, bonuses, or other compensation.**

Earnings are based on: Current level of earnings or Prior calendar year earnings

Option 2:

Basic earnings **exclude other compensation or overtime but include:** Commissions Bonuses

Earnings are based on the average of the most recent:

24 Months 36 Months Prior calendar year Prior 2 calendar years Prior 3 calendar years

Option 3: (Partners only)

Average earnings calculated from the Partnership Federal Income Tax return for the immediately prior:

Tax Year Calendar Year

This definition of earnings option selected above applies to:

All Coverages or Applies only to: Life STD LTD

All Classes or Applies only to class _____

Important: "Basic earnings" means an employee's gross rate of earnings from the employer. It includes employee pre-tax contributions to a qualified deferred compensation plan, 401 (K) plan, or Section 125 plan.

This definition defines the base against which the premium and benefits will be paid. If any employee's compensation is not reported on a W-2 or if any employee is paid on a basis other than salaried or hourly, please provide specifics. The term "Basic Earnings" refers to: an annualized amount for Life/AD&D, a weekly amount for Short Term Disability, and a monthly amount for Long Term Disability.

LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) 2 to 24 Lives

Benefit Schedules:

Option 1 Coverage based on _____ times each employee's annual earnings to a maximum of \$_____.

Option 2 Coverage based on job or payroll classification (A minimum of two employees per class is required.)

Classification	Basic Life/AD&D Amount	Maximum \$ Benefit
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Option 3 \$_____ Coverage for each employee

Dependent Life Option: Yes No Requires 10 or more employees enrolled and at least 75% of employees with dependents enrolled

Minimum Waiting Period 30 days (Standard) If longer, specify length _____

From Date of Hire (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Participation Total # of Eligible Employees _____
 Total # of Employees Applying _____
 Total # of Employees with Dependents _____

Number of Employees	Non-Medical Maximum Limit*	Maximum With Evidence	Minimum Participation Required
Insure 2 to 5	\$25,000	\$200,000	All Eligible
Insure 6 to 9	\$50,000	\$200,000	All or All but One
Insure 10 to 24	\$75,000 or 3 times the average benefit, whichever is less	\$300,000	75% of those eligible

* Amounts elected in excess of the non-medical maximum limit will require medical underwriting which may include, but is not limited to, physical exams and blood testing.

Employer Will Pay: _____ % of Employee costs
 _____ % of Dependent costs

(Employees may contribute up to 100% of the premium.)

Will this policy replace any existing policy of life insurance? **Employer:** Yes No **Producer:** Yes No

DENTAL (3 to 24 Lives)

Plan Selected (annual plan maximum) Brass (\$1000) Silver (\$1200) Gold (\$1200) Platinum (\$1500)

With PPO Yes No **With Vision** Yes No

Is this plan replacing another group plan? Yes No

If yes, attach a copy of the prior carrier's last bill and copy of certificate(s) of insurance and complete the following:

Prior Carrier effective date _____

Name of Carrier(s) being replaced _____

Coverage(s) provided _____ Termination Date(s) _____

Reason(s) for change _____

Waiting Period

- There is a 24 month waiting period for orthodontic coverage. (Only available with Platinum Plan.)
- There is a 12 month major services waiting period for all insured employees, unless they meet the requirements for a waiting period waiver. This benefit waiting period may be waived if the employer has existing group dental insurance, including comparable coverage for major services. The waiver will be granted to any employees who, on the day before their effective date for this coverage, would have been reimbursed for major services under the prior dental coverage. All employees that have satisfied the above requirements will be granted a waiver; there will not be any waivers for any future employees. (Only available with Silver, Gold and Platinum Plans.)

Is the employer eligible for a waiver? Yes No

(If yes, a copy of the existing dental plan, the last bill and proof of individual effective dates must be submitted.)

Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)? Yes No

Note: Your maximum coverage period will be measured from loss of coverage.

Is any person eligible to receive future benefits under your terminated plan, i.e., COBRA continuant? Yes No

If yes, list below the name(s) of the employees and/or dependents under COBRA for Dental coverage only, date of qualifying event and type of qualifying event (termination of employment, death, divorce, child reaching the limiting age):

Name	Date	Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

Minimum Waiting Period From Date of Hire 30 days (Standard) If longer, specify length _____
(Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Participation: Total # of Eligible Employees _____ (Excluding employees who waive dental coverage because they have such coverage through their spouses.)
 Total # of Employees Applying _____
 Total # of Eligible Employees with Dependents Applying _____

Employer Will Pay: _____ % of Employee costs (The employee may contribute up to 100% of the premium.)
 _____ % of Dependent costs

SHORT TERM DISABILITY (2 to 24 Lives)

Plan Duration 13 weeks 26 weeks

Plan of Benefits

Option 1 Percentage of Earnings Plan 50% 60% 66.7% 70%
Maximum per week \$_____ (Plan maximum \$750 if 2-5 lives; \$1,000 if 6-24 lives)

Option 2 Flat Benefit by Class (A minimum of two employees per class is required.)
Description of Class Benefit Amount (Plan maximum \$750 if 2-5 lives; \$1,000 if 6-24 lives; benefit limited to 70% of the employee's earnings)

1. _____	\$_____ per week
2. _____	\$_____ per week
3. _____	\$_____ per week

Option 3 \$_____ benefit for each employee (Benefit limited to 70% of the employee's earnings)

Minimum Waiting Period 30 days (Standard) If longer, specify length _____

From Date of Hire (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Participation Total # of Eligible Employees _____
Total # of Employees Applying _____

Employer Will Pay: _____% of Employee costs (Employees may contribute up to 100% of the premium.)

Group has been in business for six (6) months or longer Yes No

Group is currently participating in Federal Social Security Program Yes No

Employees work where they reside (work out of their homes) Yes No
(Eligible employees must be working at the employer's usual place of business.)

LONG TERM DISABILITY (2 to 24 Lives)

Plan Selected* Base Plan: • Standard Risk Employees-up to age 65 for accident / the lesser of 5 years or up to age 65 for illness
• Preferred Risk Employee¹-up to age 65 for accident / illness
 Transitional Plan: • All Employees-up to 24 months for accident / illness
* Plan eligibility is based on SIC/nature of business.

Elimination Period 60 days 90 days 180 days

Benefit Formula 60% of Basic Monthly Earnings to a monthly maximum benefit of:
 \$2,000 \$3,000 \$4,000 \$5,000 \$6,000

Is this plan replacing another group plan?
 Yes (If yes, attach a copy of the prior carrier's last bill and copy of certificate(s) of insurance for prior service credit)
 No

Minimum Waiting Period 90 days (Standard) If longer, specify length _____

From Date of Hire (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Participation Total # of Eligible Employees _____
Total # of Employees Applying _____

Employer Will Pay: _____% of Employee costs (Employees may contribute up to 50% of the premium.)

Group has been in business for twelve (12) months or longer Yes No

Group is currently participating in Federal Social Security Program Yes No

Employees work where they reside (work out of their homes) Yes No
(Eligible employees must be working at the employer's usual place of business.)

1 Preferred Risk employees are classified as executive, administrative, sales, supervisory and clerical employees who have no manual labor duties and spend at least 80% of their time inside the office.

NOTIFICATION OF WAIVER FORM (This form may be photocopied)

Please read, complete and sign this form if you have benefits under a spouse's coverage and/or contribute toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, Short Term Disability and/or Long Term Disability.

Note: Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage.

However, election to waive may not exclude that employee from the employer's participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined in the plan brochure.

Employee's Name: _____

Name of Employer: _____ Account #: _____

Date of Birth: _____ Social Security #: _____

Please check the box for type(s) of insurance coverage you are waiving:

Life Dental Short-Term Disability Long-Term Disability

If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable.

I have similar dental coverage under my spouse's plan; and/or

My dependents have similar dental coverage under my spouse's plan.

If either or both above boxes are checked, please provide the following information:

Name of spouse's insurance company: _____

Spouse's plan effective date: _____

I do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage.

My dependents do not have similar dental coverage under my spouse's plan, but I am waiving the dependent dental coverage.

Please read and sign:

I affirm that I have reviewed the insurance plan(s) from Sun Life and Health Insurance Company (U.S.), offered by my employer. By signing below, I have decided to waive coverage as indicated above.

I understand that if I decide to enroll later, I will be considered a late entrant and may be subject to Evidence of Insurability and/or reduced benefits.

Signature _____ Date _____

CENSUS INFORMATION & APPLICATION SIGNATURES

Important Note: Make a copy of this page if enrolling more than 12 employees. Complete and attach it to this form. Please print or type census information.

Employee's Social Security Number	Name	Date of Birth M/D/Y	Gender M/F	Date of Hire M/D/Y	Occupation	Class	Current Monthly Salary	Hours worked per week	Coverage Selected					
									LTD	STD	Dental	Life/ AD&D	Dep Life ⁴	
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														

- Any employee marked as "Preferred Risk" meets the definition of a "Preferred Risk Employee" i.e., they are classified as in-office executive, administrative, sales, supervisory and clerical employees who have no manual duties and spend at least 80% of their time inside the office.
- Indicate: "S" for single, "+1" for employee plus one dependent or "F" for family coverage.
- Must have 10 to 24 insureds to be eligible for Dependent Life coverage.

(continued on next page)

PRODUCER'S STATEMENT

Name of Employer to be Insured _____

Attention Producers: This Enrollment Form must be completed in full. Missing information will delay the new business process and your COMMISSIONS! Make sure ALL items on the list on the front of this form are included.

If not currently appointed, complete all applicable sections of this form and contact our Licensing area at 800 451.2513 (press zero at prompt, then x2534) for contracting material. We will also require a copy of your license and your firm's license if applicable.

Any product related questions should be directed to the E-Z Choice Unit at 1-877-EZChoice.

Writing Producer 1 _____ % of payable commissions

Name _____
Last Name First Name Middle Initial

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # or Individual SS # _____

State License # _____ State _____

SLHIC (U.S.) Producer Code _____

Phone () _____

Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? Yes No

Signature _____ Date _____

Writing Producer 2 (if applicable) _____ % of payable commissions

Name _____
Last Name First Name Middle Initial

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # or Individual SS # _____

State License # _____ State _____

SLHIC (U.S.) Producer Code _____

Phone () _____

Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? Yes No

Signature _____ Date _____

Only complete the section below if you have been appointed as a SLHIC (U.S.) General Agent or Master General Agent.

General Agent (if applicable)

GA Name _____
Last Name First Name Middle Initial

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # or Individual SS # _____

State License # _____ State _____

SLHIC (U.S.) Producer Code _____

Phone () _____

Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? Yes No

Questions about this case, contact Producer General Agent

GA Contact Name _____

Master General Agent

MGA Name CPS Group Benefits Insurance Services, Inc.
Last Name First Name Middle Initial

Firm Name CPS Group Benefits Insurance Services, Inc.

Firm Address 18551 Von Karman Ave. Suite 150

City Irvine State CA ZIP 92612

Firm Tax ID # or Individual SS # 20-8421265

State License # 0F65276 State CA

SLHIC (U.S.) Producer Code 200574

Phone (949) 225-7160

Fax (949) 225-7160

E-mail Address pbeh@cpsinsurance.com

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? Yes No

Questions about this case, contact Producer General Agent

Master General Agent

MGA Contact Name Philip Beh & CPS Group Benefits