Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
Attn: Group Eligibility - WIN 407
175 Addison Road, PO Box 725
Windsor, CT 06095-0725

ENROLLMENT REQUEST

☐ **Add** ☐ **Change** ☐ **Termination** ☐ **Correction**

Date: _____ **Reason:** _____

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group
246-6772-00				

4. Name of Employer: Somerset Trust Company

5. Employer's Address (Number, Street, City, State, ZIP Code): P.O. Box 777 Somerset, PA 15501

** **Employee Information - to be completed by Employee** (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.)

7. Social Security Number

8. Employee's Address (Number, Street, City, State, ZIP Code)

9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female

11. Date of Birth (Mo., Day, Yr.)

12. Marital Status ☐ Single ☐ Married

13. My employment is covered under Union Collective Bargaining ☐ Yes

14. Hours worked weekly for this employer (Excluding Overtime) _____ ☐ Active ☐ Retired

15. Date Employed (Mo., Day, Yr.) ☐ Full-Time ___/___/___ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___

16. Basic Earnings $ _____ ☐ Hourly _____ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually

17. Employee's Occupation (Title)

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Life/~~AD&D~~	☑ I Elect	☐ I Refuse	Dependent Life/AD&D	☐ I Elect	☐ I Refuse	Supplemental Life/AD&D	☐ I Elect	☐ I Refuse
Dental	☐ I Elect	☐ I Refuse	Medical	☐ I Elect	☐ I Refuse	Weekly Indemnity/STD	☐ I Elect	☐ I Refuse
Dependent Dental	☐ I Elect	☐ I Refuse	Dependent Medical	☐ I Elect	☐ I Refuse	Long Term Disability	☑ I Elect	☐ I Refuse

*If you have refused Medical or Dental, is it because you have other Group Coverage?
Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage?
Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Please Complete The Following Question If You Are Electing Medical Coverage

N/A d you or your dependent have prior medical coverage? ☐ Yes If so, ☐ Single ☐ Family ☐ Dependent(s)

☐ Individual Policy ☐ Group Policy ☐ HMO ☐ Other _____

Name of Carrier _____ Termination date of Coverage ____/____/____

Reason for Termination _____

N/A **Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.**

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee				/ /		/ /
				/ /		/ /
				/ /		/ /
				/ /		/ /
				/ /		/ /

Student Verification - Please complete the following if any child listed is a full-time college student.

N/A Name of Child: _____ School Name and Address: _____

Course of Study: _____ Semester: _____ Anticipated Date of Graduation (month/year): _____

** **Beneficiary Designation - applies ONLY if life insurance is being elected at this time**

22. Primary - Last Name	First Name & Middle Initial	Relationship	Address
23. Contingent - Last Name	**First Name & Middle Initial**	**Relationship**	**Address**

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

NOTE: YOU MUST SIGN THE BACK OF THIS FORM FOR THIS REQUEST TO BE VALID

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge and belief and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment may result in my coverage being contested subject to the incontestability provision and that all statements made by me shall be deemed to be representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge and belief I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the **refusal section** is correct and my signing below indicates that I understand all information given is subject to verification.

**	24. Date	25. Signature

WARNING

Disability income benefits may be reduced by other sources of income. Read your certificate carefully.

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 (in North Carolina, "may subject") subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

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 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 knowingly files a statement of claim containing any false or misleading information 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 concerning 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. THIS NOTICE DOES NOT APPLY TO AN APPLICATION FOR LIFE INSURANCE."

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 https://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.