Sun Life Financial

Group Enrollment form

Sun Life Financial®

☐ 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

Employer name	Account/policy number	Location	Date effective
Ollie's Bargain Outlet, Inc.	055 4350 01		

Street address	City	State	Zip code
		PA	

Type of activity: ☐ New Enrollment ☐ Change Reason:	Occupation

2 Employee information

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth

Street Address	City	State	Zip Code

Marital Status	Social Security Number	Phone number

Date employed: ☐ Full-Time Date: ☐ Part-Time Date: ☐ Rehire ☐ Return from layoff Date:

Current Active Employment Type _____ # of hours ☐ Full-Time ☐ Part-Time	Employee Status: ☐ Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired	Salary

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. See the Evidence of Insurability section for details.

3 Benefit elections

Voluntary Life and AD&D coverage: Underwritten by Sun Life and Health Insurance Company (U.S.) (Wellesley, MA)

	Elect Life and AD&D	Refuse Life and AD&D	Coverage amount elected
Employee coverage:	☐	☐	Life and AD&D:
Spouse coverage**:	☐	☐	Life and AD&D:
Child(ren) coverage**:	☐	☐	Life and AD&D:

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

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 (First, MI, Last)	Gender	Social Security number	Date of birth	Check if elected Dep Life
Spouse / Partner					☐
Children					☐
					☐
					☐

5 Beneficiary Designation information

Primary Beneficiary Designation

Voluntary Life and 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 beneficiaries are alive at the time of your death, proceeds will be payable in accordance with your Group insurance policy.

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

Basic Life and AD&D Insurance– 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 your 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 Evidence of insurability and authorization information

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for a higher coverage than the Maximum Guaranteed Issue amount
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier
- decline coverage and then want it at a later date

Coverage is subject to evidence of insurability and will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- 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 which is acceptable to Sun Life and Health Insurance Company (U.S.). I have read the Evidence of Insurability notice.
- 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.

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.

7 Employer information

For Employer Use Only
Provide the employee's earnings amount below.

Indicate pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

All Coverage Earnings $	☐ Annual ☐ Semi-Monthly ☐ Weekly ☐ Monthly ☐ Bi-Weekly	☐ Hourly Number of hours worked per week: _____

Contact us

By mail
Sun Life Financial
One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

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

Sun Life Financial

Evidence of Insurability instructions

Sun Life Financial®

1 Employer instructions

Complete sections 2 and 3 and then give this page and the application to the employee. The employee and/or dependent requesting coverage subject to Evidence of Insurability ("EOI") must fill out the application and include this instructions page with his or her submission. Failure to include the completed instructions page will delay the EOI process.

2 Employee information (to be completed by employer)

Employer name	Group policy number	Division/location	Billing code

Employee name (first, middle initial, last)	Social Security number – –

Please indicate the requested effective date of each coverage subject to EOI:

3 Coverage(s) subject to Evidence of Insurability (to be completed by employer)

Select coverage(s) for which EOI is required. Fill in all applicable fields. Disability Insurance is available to employees only. Need help determining EOI amount? Please see your **Group Policy** and the **Administrator's Guide**.

	Current coverage amount in force (Include any Guaranteed Issue coverage if eligible and any coverage existing prior to this application. If "none," put "$0" in the box.)	**Total amount request** (Enter the total coverage amount requested in dollars)
Employee Basic Life	$	$
Employee Optional Life	$	$
Employee Voluntary Life	$	$
Spouse Basic Life	$	$
Spouse Optional Life	$	$
Spouse Voluntary Life	$	$
Child Basic Life	$	$
Child Optional Life	$	$
Child Voluntary Life	$	$

☐ Short-Term Disability	☐ Long-Term Disability	☐ Long-Term Disability Buy-Up

☐ Customized Disability

Name of person completing the above sections (please print)	Signature of person completing the above sections X	Date

4 Employee instructions

Complete, sign, and submit either the online EOI Application or the printable EOI Application, but <u>not both</u>.

- **Online EOI Application (available for Group policy numbers with six digits or less)**
  1. Go to www.mysunlifebenefits.com.
  2. Follow the instructions. Enter height, weight, date of birth and medical history for you and any dependents on this application.
- **Printable EOI Application**
  1. Complete pages 2 through 5 of the EOI Application. Please remember to sign and date the form.
  2. Mail or fax the EOI Application and this instructions page to:

     MAIL TO: Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481; or

     FAX TO: 781-304-5137

You are required to notify, in writing, Group Medical Underwriting of any changes in your health to the best of your knowledge, between the date you sign the application and the date coverage is approved.

Sun Life Financial

Evidence of Insurability Application – Health Questionnaire

☐ 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

- You are applying for coverage from one of the insurance companies above, outside of New York, which is referred to as "The Company" on this application. Please refer to your Plan Administrator for the correct underwriting company.
- Complete and return the entire application and the instructions page to Sun Life Financial.

1 Employee information (Please print clearly)

Employer name	Group policy number	Division/location	Billing code

Employee name (first, middle initial, last)			

Employee street address	City	State	Zip code

Social Security number – –	Daytime phone number	Evening phone number

E-mail address	Occupation

2 Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by The Company. No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

	First name	Last name	DOB (mm/dd/yyyy)	Height	Weight	Gender
Employee						☐ M ☐ F
Spouse/ partner						☐ M ☐ F
Child 1						☐ M ☐ F
Child 2						☐ M ☐ F
Child 3						☐ M ☐ F

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	**Employee**		**Spouse/ partner**		**Child(ren)**	
	Yes	No	Yes	No	Yes	No
1. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
2. Stroke, transient ischemic attack (TIA), high blood pressure, irregular heart beat, heart murmur, aneurysm, heart attack, angina, elevated cholesterol, or any blood, heart, or blood vessel disorder?	☐	☐	☐	☐	☐	☐
3. Cancer, leukemia, tumor, neoplasm, nodule or polyp (excluding nasal polyp), pre-cancerous condition, or dysplastic nevi?	☐	☐	☐	☐	☐	☐
4. Diabetes, hepatitis, or other disorder of the liver or pancreas; thyroid, pituitary or other endocrine disorder; ulcer, colitis or Crohn's disease, diverticulitis, or other gastrointestinal disorder?	☐	☐	☐	☐	☐	☐
5. Disorder of the kidney, bladder (excluding healed bladder infections or urinary `system, or reproductive organs?	☐	☐	☐	☐	☐	☐

2 Health and personal history, continued

(Complete the following for all persons applying for coverage requiring underwriting)

Have you or any of your dependents (spouse/partner, child(ren)) ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
6. Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, cystic fibrosis or any lung or respiratory disorder?	☐	☐	☐	☐	☐	☐
7. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus; connective tissue disease; or fibromyalgia?	☐	☐	☐	☐	☐	☐
8. Headaches, epilepsy, seizures, paralysis, memory loss, intellectual disability, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), multiple sclerosis, muscular dystrophy, or any brain or neurological disorder, chronic infection, or chronic fatigue?	☐	☐	☐	☐	☐	☐

In the last ten years have you or any of your dependents ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
9. Skin disorder that lasted for more than 6 months?	☐	☐	☐	☐	☐	☐
10. Anxiety, depression or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder; or schizophrenia?	☐	☐	☐	☐	☐	☐
11. Disorder of the eyes or ears (excluding healed ear infections)?	☐	☐	☐	☐	☐	☐
12. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	☐	☐	☐	☐	☐	☐

In the last ten years have you or any of your dependents:	Employee		Spouse/ partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?	☐	☐	☐	☐	☐	☐
14. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional?	☐	☐	☐	☐	☐	☐
15. Been off work for more than five consecutive days due to an illness or injury?	☐	☐	☐	☐	☐	☐
16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been arrested in connection will alcohol or drugs; or received treatment in connection with alcohol or drugs?	☐	☐	☐	☐	☐	☐
17. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended?	☐	☐	☐	☐	☐	☐
18. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	☐	☐	☐	☐	☐	☐
19. Are you or one of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐

Have you or any of your dependents:	Employee		Spouse/- partner		Child(ren)	
	Yes	No	Yes	No	Yes	No
20. In the last 2 years, piloted an aircraft, engaged in motor vehicle racing, auto racing, boat racing, hang gliding, parachuting, climbing, scuba diving, or any similar sport or avocation?	☐	☐	☐	☐	☐	☐
21. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	☐	☐	☐	☐	☐	☐
22. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional?	☐	☐	☐	☐	☐	☐

3 **Details** (provide details below for all questions answered "yes.")

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question number	Applicant name	State and provide details for each condition and activity	Date condition began	Duration of condition and treatment	Physician name, address and phone number	Fully recovered?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Please provide physician information even if you answered "no" to all the questions.

Name and address of physician with your most up-to-date and comprehensive medical records:

4 Acknowledgement, authorization for release and disclosure of health related information and signature

Acknowledgement

I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.

If I have any questions regarding my EOI Application, I can write to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481.

4 Acknowledgement, authorization for release and disclosure of health related information and signature, continued

I AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or healthcare facility that has provided payment, treatment, or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Medical Underwriting Department of Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but does not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to [Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Signature of employee X	Date signed
Signature of spouse/partner (If application is for spouse/partner) X	Date signed

5 Fraud warnings

General fraud warning: 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 subjects such person to criminal and civil penalties.

For AL the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For AR, LA, MA, NM, RI, and WV the following fraud warning applies: 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.

For CO the following warning applies: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award
payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For the District of Columbia the following notice applies: 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.

5 Fraud Warnings, continued

For FL the following notice applies: 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.

For KS the following notice applies: 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 may be guilty of insurance fraud as determined by a court of law.

For KY the following notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, 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.

For MD the following notice applies: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For ME, TN, and WA the following notice applies: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For NJ the following notice applies: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For OH the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud**.**

For OK the following notice applies: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For OR and VA the following notice applies: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

For PR the following notice applies: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For VT the following notice applies: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Contact us

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