



Sun Life Financial
Employee Benefits Group

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

Group Dental Enrollment Request

Add Change Termination Correction
Date: _____ Reason: _____

Account Number		Name of Employer	
Basic Plan	039-5931-00	AJM Leasing Company: Account Number 039-5931-00 / 039-5931-01	
Enhanced Plan	039-5931-01		
Employee Name		Employee Address	
Social Security Number	Gender	Date of Birth	
Hours worked / week	Date of Hire	Annual Earnings	Occupation/Title

Dental Benefits Requested - Please select one of the following:

- I elect to enroll in the **Basic** dental plan
- I elect to enroll in the **Enhanced** dental plan
- I decline Dental Benefits *

* Note: If you decline benefits for yourself you automatically decline benefits for your dependents. If you decline benefits now and later request to add the benefit, your coverage may be limited as outlined in the plan certificate of coverage.

If you are electing to enroll for Dental Benefits please select one of the following:

- Employee only coverage
- Coverage for Employee and One Dependent
- Coverage for Employee and all Eligible Dependents

Note: During the Annual Selection Period, employees may switch between the Basic and Enhanced plans. The selection period will occur during the month of December each year.

Complete the following if you are selecting coverage for your dependents:

Relationship	Last Name	First Name / M.I.	Date of Birth	Gender	S.S. Number

Student Verification - Please complete the following if any child over the age of 19 is a full-time student:

Name	School and Address (City, State)	Anticipated Date of Graduation (MM/YYYY)

You must read and sign this statement in order to request coverage through your employer.

I have read and personally responded to each of the preceding questions and have confirmed that the information is correct. I request insurance under the group coverage issued to my employer by Sun Life and Health Insurance Company (SLHIC). I authorize deductions from my earnings of any required contributions for any insurance for which I am or may later become eligible. I certify that: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) I understand that any incorrect statements may result in my coverage or my dependents' coverage being terminated, rescinded and/or claims not paid; (3) I have read this form; (4) I authorize SLHIC to verify all information.

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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE OF EMPLOYEE:	DATE:
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