Sun Life Assurance Company of Canada

Portability Notice

1 Employer information

Instructions:

- Please complete all sections of this form.
- Inform the employee that he or she has 31 days from the date of termination to apply for Portability. (Some policies allow more time. Check your group insurance booklet/certificate.)
- Provide the employee with:
  - This completed form and all required attachments
  - Applicable employee kit for Group Portability
  - Portability application(s)

Name of group policyholder	Group policy number(s)
Name of person completing this form (employer administrative contact)	
Title	Phone number

2 Employee information (to be completed by the employer)

Name of employee (first, middle initial, last)		Class	Choice / option (if applicable)
Date of birth (mm/dd/yyyy)	Social Security number	Basic annual salary	Date last worked (mm/dd/yyyy)
Date of termination (mm/dd/yyyy)		Date optional coverage terminates (if different) (mm/dd/yyyy)	

1. Did the employee stop working due to injury or sickness? ..... ☐ Yes ☐ No
2. Has a Waiver of Premium claim been filed? ..... ☐ Yes ☐ No
3. Are premiums still being paid by the employer?..... ☐ Yes ☐ No
   If "Yes," indicate what date the premiums are paid to (mm/dd/yyyy):..... _____

3 Coverage amount(s) at time of employee's termination (to be completed by the employer)

Life insurance coverage amount — Check here if not applicable ☐

Employee Basic Life	$	**Employee Optional/Voluntary Life**	$
Employee Basic AD&D	$	**Employee Optional AD&D**	$
Spouse Basic Life	$	**Spouse Optional/Voluntary Life**	$
Spouse Basic AD&D	$	**Spouse Optional AD&D**	$
Child Basic Life	$	**Child Optional/Voluntary Life**	$
Child Basic AD&D	$	**Child Optional AD&D**	$

Required attachments for life insurance coverage:

☐ A copy of the employee's enrollment form and proof of any changes in insurance since the employee's enrollment date

3 **Coverage amount(s) at time of employee's termination,** continued (to be completed by the employer)

Life insurance coverage amount, continued

Employee Stand-Alone Voluntary AD&D	$
Spouse Stand-Alone Voluntary AD&D	$
Child Stand-Alone Voluntary AD&D	$

Disability insurance coverage amount — Check here if not applicable ☐

Enter the employee's current benefit as an amount of insurance, rather than a percentage of income. For example, if the employee's current benefit is 60% and their weekly salary is $1,000, enter $600.

Short-Term Disability	$

Required attachments for disability insurance coverage:

☐ A copy of the employee's enrollment form and proof of any changes in insurance since the employee's enrollment date

☐ A copy of the employee's formal job description or a detailed description of primary duties

Critical Illness insurance coverage amount — Check here if not applicable ☐

Employee Critical Illness Only insurance $	**Employee Critical Illness and Cancer insurance** $	**Employee Critical Illness, Cancer Only insurance** $
Spouse Critical Illness Only insurance $	**Spouse Critical Illness and Cancer insurance** $	**Spouse Critical Illness, Cancer Only insurance** $
Child Critical Illness Only insurance $	**Child Critical Illness and Cancer insurance** $	**Child Critical Illness, Cancer Only insurance** $

1. Does the employee's plan include the Recurrence benefit? ..... ☐ Yes ☐ No
2. Does the employee's plan include the Wellness benefit? ..... ☐ Yes ☐ No
3. If Wellness is included, what is the reimbursement amount? ..... ☐ $50 ☐ $100

Required attachment for Critical Illness insurance coverage:

☐ A copy of the employee's enrollment form and proof of any changes in insurance since the employee's enrollment date

3 Coverage amount(s) at time of employee's termination, continued (to be completed by the employer)

Accident insurance coverage amount

Check here if not applicable ☐

Accident insurance		Spouse and child insurance	
☐ High plan ☐ Mid plan ☐ Low plan	$		$

Employee Accident Disability insurance		Spouse Accident Disability insurance	
☐ High plan ☐ Mid plan ☐ Low plan	$		$

Required attachment for Accident insurance coverage:

☐ A copy of the employee's enrollment form and proof of any changes in insurance since their enrollment date

4 Signature

Signature of employer administrative contact completing this form X	Date (mm/dd/yyyy)

Contact us

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