



## 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  
If "Yes," indicate which coverage(s)
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:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)

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

Life insurance coverage amount, continued

<b>Employee Stand-Alone Voluntary AD&amp;D</b>	\$
<b>Spouse Stand-Alone Voluntary AD&amp;D</b>	\$
<b>Child Stand-Alone Voluntary AD&amp;D</b>	\$

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.

<b>Short-Term Disability</b>	\$
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Required attachments for disability insurance coverage:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)
- 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

<b>Employee Critical Illness insurance</b>	\$	<b>Spouse Critical Illness insurance</b>	\$	<b>Child Critical Illness insurance</b>	\$
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Required attachment for Critical Illness insurance coverage:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)

Accident insurance coverage amount

Check here if not applicable

<b>Employee Accident insurance</b> Current plan (if multiple choice, i.e. Low plan, High plan)	<b>Spouse and Child insurance</b> Spouse covered <input type="checkbox"/> Yes <input type="checkbox"/> No Child(ren) covered <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Employee Accident Disability insurance</b> Weekly benefit \$ Elimination period days Max duration weeks	<b>Spouse Accident Disability insurance</b> Weekly benefit \$ Elimination period days Max duration weeks
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Required attachment for Accident insurance coverage:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)

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

Cancer insurance coverage amount

Check here if not applicable

<b>Employee Cancer insurance</b> Plan level	<b>Spouse and child insurance</b> Spouse covered <input type="checkbox"/> Yes <input type="checkbox"/> No Child(ren) covered <input type="checkbox"/> Yes <input type="checkbox"/> No
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Required attachment for Cancer insurance coverage:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)

Hospital Indemnity insurance coverage amount

Check here if not applicable

<b>Employee Hospital Indemnity insurance</b> Current plan (if multiple choice, i.e. Low plan, High plan)	<b>Spouse and Child Hospital Indemnity insurance</b> Spouse covered <input type="checkbox"/> Yes <input type="checkbox"/> No Child(ren) covered <input type="checkbox"/> Yes <input type="checkbox"/> No
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Required attachment for Hospital Indemnity insurance coverage:

- Proof of the employee's benefit elections and any changes in insurance since their enrollment date (such as an enrollment form or confirmation/coverage statement)

### 4 Signature

Signature of employer administrative contact completing this form  
X

Date (mm/dd/yyyy)

### Contact us



#### By mail

Sun Life Assurance Company of Canada  
96 Worcester Street  
Wellesley Hills, MA 02481



[www.sunlife.com/us](http://www.sunlife.com/us)



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

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