Administrative Services Only Dental Employee Application

Sun Life Financial®

☐1st application ☐Adding dependent ☐Effective date_____

ALL AREAS MUST BE COMPLETED OR FORM WILL BE RETURNED; ***PRINT LEGIBLY OR TYPE.***

EMPLOYEE INFORMATION

Name of employer	Plan no.	Division no.
Episcopal Diocese of Alabama	904211	

Name of employee *(last, first, middle initial)*	Part-time employment date Mo Day Yr	Full-time employment date Mo Day Yr

Home address of employee *(street, city, state, zip code)*

Job title	Hours worked per week for this firm	Employee date of birth Mo Day Yr	Social Security no.	☐Male ☐Female	☐ Single ☐Married

List all dependents to be covered.

Last First Middle initial	Date of birth Mo/Day/Yr	Relationship to Employee

COVERAGES ELECTED **WAIVER SECTION**

I am applying for:
☐Employee Dental only
☐Employee and Spouse Dental
☐Employee and Child(ren) Dental
☐Family Dental

I am *not* applying for the following coverage for which I am eligible:
☐Employee Dental Reason_____
☐Spouse Dental Reason_____
☐Child(ren) Dental Reason_____

PLEASE READ CAREFULLY: I wish to apply for coverage under the dental plan administered by Sun Life Assurance Company of Canada. I authorize my employer to deduct **premiums** from my earnings.

AUTHORIZATION TO RELEASE INFORMATION: For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, insurance company, consumer reporting agency, employer, or any other organization to give Sun Life Assurance Company of Canada or its reinsurers, ALL INFORMATION on my behalf including findings on dental care as they apply to me or any of my dependents who are to be covered.

I know that I have a right to a copy of this authorization. A photocopy will be as valid as the original. This authorization will be valid for two and one half years (in Minnesota, 26 months) from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Sun Life Assurance Company of Canada to use and disclose protected health information.

Signature of employee_____ Date_____

FOR COMPANY USE ONLY

Effective date_____ Date received_____

Sun Life Assurance Company of Canada
Sun Life Financial P.O. Box 981624 El Paso, Texas 79998-1624
T 800.757.9796 F 816.474.2422