mea Financial Services

Voluntary Group Life with AD&D

MUST COMPLETE SECTIONS 1-5

1 NEW ENROLLMENT

Select One

- ◉ Employee (member)
- ○ Spouse/Partner
  (must complete separate app)

2 COVERAGE REQUESTED

- ☐ Life with Accidental Death & Dismemberment (AD&D)
- ☐ Dependent Child(ren) Life with AD&D
  (in addition to parent's coverage)

3 AMOUNT OF COVERAGE DESIRED

EMPLOYEE

- ☐ **$10,000 to $500,000**
  in increments of $10,000
  Amount: _____

SPOUSE

- ☐ **$10,000 to $250,000**
  in increments of $10,000
  Amount: _____

CHILD

- ☐ **$10,000 to $30,000**
  in increments of $1,000
  Amount: _____

Evidence of insurability/medical underwriting may be required.

FOR OFFICE USE ONLY

Current Coverage: _____
Effective Date: _____
Certificate # _____
Approved: _____
Entered: _____

4 COMPLETE THE FOLLOWING

FULL NAME

Last	First	M.I.	Social Security Number

BILLING ADDRESS

Street or P.O. Box	City	State	Zip

EMPLOYEE'S CONTACT INFORMATION

Email Address	Cell Phone

BENEFICIARY/IES FULL NAME AND RELATIONSHIP

The insured member is the beneficiary for the dependent(s).

Are you or your spouse actively working at a school district or an eligible employer (MEA, MESSA or MEA Financial Services)? ☐ **YES** ☐ **NO**

NAME OF EMPLOYER/SCHOOL

If applying for spouse coverage, give name of employee's employer.

NAME AND OCCUPATION OF EMPLOYEE

Name	Occupation

Date of Employment (mm/dd/yyyy): ___/___/_____

COMPLETE THE FOLLOWING FOR ALL

Name	Relationship	Sex	Date of Birth
	Applicant	—	
	Child	—	
	Child	—	
	Child	—	
	Child	—	
	Child	—	

Sun Life

SIGNATURE REQUIRED ON REVERSE ➡

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Voluntary Group Life with AD&D

Authorization

Signature Required

By my signature below 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, PO 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.

Fraud Warning

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 **SIGNATURE** _____ **DATE** _____

Coverage will be effective the first day of the month following approval.

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P.O. Box 2501

East Lansing, MI 48826-2501

800-292-1950 and press 4
or 517-351-2122

meafs.com