



**SACRAMENTO CITY UNIFIED SCHOOL DISTRICT**

**Sun Life Insurance**

**PLEASE USE BLUE OR BLACK INK ONLY**

Effective Date \_\_\_\_\_

- New Enrollment                       Name Change/Former Name \_\_\_\_\_  
 Open Enrollment                       Beneficiary Change / Update                       Address Change

Employee's Last Name	First Name, Middle Initial	Date of Birth	Social Security #
		- -	- -
Street/Mailing Address			Hire Date
City, State, Zip			/ /
Male <input type="checkbox"/> Female <input type="checkbox"/> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	Non-Certificated Voluntary Life <input type="checkbox"/> Accept <input type="checkbox"/> Decline At employee cost, \$7.92 per month Max \$15,000.00 Available upon hire or elect or delete during Open Enrollment	Management Life Insurance <b>UPE, CONF, UNREP MGMT</b> <b>\$125,000</b> Automatic enrollment unless a voluntary waiver is requested	

**Primary Beneficiary**

Last Name,	First Name	M	DOB	Relationship	Social Security #
			/ /		
Telephone Number			Email Address		
Street Address/Mailing Address				City	State      Zip
Last Name,	First Name	M	DOB	Relationship	Social Security #
			/ /		
Telephone Number			Email Address		
Street Address/Mailing Address				City	State      Zip
Last Name,	First Name	M	DOB	Relationship	Social Security #
			/ /		
Telephone Number			Email Address		
Street Address/Mailing Address				City	State      Zip

**Secondary Beneficiary**

Last Name,	First Name	M	DOB	Relationship	Social Security #
			/ /		
Telephone Number			Email Address		
Street Address/Mailing Address				City	State      Zip

In order to be covered under the Life Insurance policy, I understand that I must be either actively at work, or a former eligible employee who retired under CalSTRS or CalPERS. If I am not actively at work when the group life insurance policy becomes effective, my coverage will commence on the date I return to active work. I will be required to submit a new enrollment application at that time. For additional information, refer to Sun Life Certificate of coverage.

MY SIGNATURE BELOW IS ACCEPTANCE OF THE POLICY TERMS. I UNDERSTAND THAT THIS FORM DOES NOT MODIFY ANYTHING ON MY ORIGINAL ENROLLMENT APPLICATION EXCEPT AS I HAVE INDICATED ON THIS FORM.

\_\_\_\_\_  
Employee's or Retiree's Signature

\_\_\_\_\_  
Date Signed