

Human Resources

Benefit Services

Optional Life Insurance Coverage

Required Employee Information:

Name: _____

Employee ID: _____

S.I.N.: _____

Department: _____

Internal Address: _____

Telephone Local: _____

I wish to:

change my

enrol for

Optional Life Insurance coverage as follows:

1 x salary 3 x salary

2 x salary 4 x salary

I understand that this request for Optional Life Insurance coverage is subject to the approval of SunLife, the insurance carrier, and, if approved, the insurance will take effect on the date specified by SunLife.

Signature of the Employee

Date

Enclosure: SunLife Medical Form
To be returned to Benefit Services, FB 1130