



Benefit Plans Office

Dear Worker,

Please find enclosed an enrollment form, an Evidence of Insurability form, a summary of benefits, and a rate sheet for Optional Group Term Life (GTL) coverage through WELS VEBA and Sun Life Assurance Company of Canada. **Please complete the below information as well as the enclosed Sun Life enrollment form and return both forms to the WELS Benefit Plans Office at:**

WELS Benefit Plans Office
2949 N. Mayfair Rd. Second Floor
Milwaukee, WI 53222

You do not need to complete the section entitled “Employer Instructions” on the Cover Page of the Sun Life Evidence of Insurability Form.

Note: If you wish to obtain member coverage in the amount of \$10,000/member or \$25,000/member and the forms are completed and postmarked within the 60 day open enrollment period, you do not need to complete the enclosed Evidence of Insurability form. If you wish to obtain coverage greater than \$25,000/member and \$12,500/spouse or submit the forms beyond the 60 day open enrollment period, you will need to complete the enclosed Evidence of Insurability form for the member and all dependents requesting coverage.

You may keep the GTL summary of benefits and rate sheet for your information and records. Additional information is available on the Benefit Plans Office website at www.welsbpo.net. Questions may be directed to the Benefit Plans Office by e-mail to bpo@sab.wels.net or phone at 414-256-3860.

(Please complete the section below and return with your form)

Name: _____

Home Address: _____

Phone Number: _____

Marital Status: Married Single

Name of Employer/Sponsoring Organization: _____

Service Type: Pastor Teacher Layworker

If you do not meet the underwriting requirements for coverage greater than \$25,000, do you wish to have the \$25,000 which is available on an “open enrollment” basis: Yes No

Who should be billed for this coverage?

Employer (Name if different than above): _____

Worker

Sun Life Assurance Company of Canada

Optional Life Enrollment Form



1 Employer, Employee and Dependent Information (Please print clearly)

Name of your employer WELS VEBA Group Health Care Plan	Policy number 07528	Benefit group or class All Employees	Your annual basic earnings* \$		
Your full legal name (first, middle initial, last)	Social Security Number 	Date of birth	Date of hire	Your occupation	
Your spouse's name (first, middle initial, last)**	Social Security Number 	Date of birth	Date of marriage		
Name(s) of child(ren) to be covered (attach additional pages if needed)**			Date(s) of birth		

2 Benefit Elections (Make your benefit elections below based on the coverage options described here)

For yourself: \$10,000, \$25,000, \$50,000, \$75,000, \$100,000 or \$150,000. Amounts available with no evidence of insurability required: \$25,000. **Age Reductions:** To 65% at age 70, to 45% at age 75, and to 30% at age 80. Benefits cease at retirement.

For your spouse: 50% of the Employee Optional Life Amount. Amounts available with no evidence of insurability required: \$12,500 under age 60, and \$10,000 for age 60-69. Spouse coverage cannot exceed 50% of the employee's Optional Life coverage. Coverage ends when your spouse turns 70 years old.

For your eligible children: You can purchase \$5,000 for each eligible child. For a description of children eligible for coverage, refer to your group insurance booklet or ask your employer.

	I elect coverage	I decline coverage	Coverage amount selected
Employee coverage:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Spouse coverage*:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Child(ren) coverage*:	<input type="checkbox"/>	<input type="checkbox"/>	\$

* Your spouse and children may only be covered if you are.

3 Acknowledgment and Signature (Important: You must read and sign for coverage)

I understand that:

- I am requesting Optional Life coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage for me or my family now and want it at a later date, I/we will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the "About Evidence of Insurability" notice on page 2.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Optional Life coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- If my spouse or any of my dependent children are hospital-confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer hospital-confined and are able to perform their normal activities.

Signature of employee X	Date signed
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About Evidence of Insurability (also known as Proof of Good Health):

Evidence of Insurability (EOI) is needed if:

- You apply for higher coverage than the limits described in the Coverage Options above.
- You want to increase your existing coverage now (whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier).
- You want to increase your coverage at a later date.
- You decline coverage and then want it at a later date.

If EOI is needed, your coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

4 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event of your death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

- Use my Basic Life beneficiaries** – Check this box and leave this section blank if you want your Optional Life Insurance beneficiaries to be the same as your Basic Life beneficiaries.

If you did not check the box above, make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Primary beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

Secondary (Contingent) beneficiary(ies)	Social Security Number	Relationship to employee	Percent share of proceeds *
1.			
2.			

* The total within each class (Primary and Secondary) must equal 100%.

5 Calculating Your Cost (Find your monthly cost by adding all of the coverages you have selected)**Employee and spouse coverage:**

1. Find your/your spouse's age in the chart below and the corresponding cost.
2. Multiply the cost per \$1,000 by your/your spouse's amount of coverage (divided by 1,000). Your cost will increase when you or your spouse moves into a new age band.

Child(ren) coverage:

1. Find the cost per \$1,000 for child(ren) coverage in the chart below.
2. Multiply the cost per \$1,000 by your child(ren)'s amount of coverage (divided by 1,000).

EMPLOYEE		SPOUSE		CHILD(REN)	
Age	Monthly cost per \$1,000 of coverage	Age	Monthly cost per \$1,000 of coverage	Monthly cost per \$1,000 of coverage	
Under 25	\$ 0.08	Under 25	\$ 0.08	All eligible children \$ 0.122	
25 – 29	\$ 0.08	25 – 29	\$ 0.08		
30 – 34	\$ 0.08	30 – 34	\$ 0.08		
35 – 39	\$ 0.09	35 – 39	\$ 0.09		
40 – 44	\$ 0.10	40 – 44	\$ 0.10		
45 – 49	\$ 0.15	45 – 49	\$ 0.15		
50 – 54	\$ 0.23	50 – 54	\$ 0.23		
55 – 59	\$ 0.43	55 – 59	\$ 0.43		
60 – 64	\$ 0.66	60 – 64	\$ 0.66		
65 – 69	\$ 1.27	65 – 69	\$ 1.27		
70 +	\$ 2.06				

Employee: Make a copy of this form for your records before submitting it to your employer.

Employers: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another Optional Life Enrollment Form.

Sun Life Assurance Company of Canada

Evidence of Insurability Cover Page



Employer Instructions

Complete this cover page and provide it to the employee. The employee may complete the Evidence of Insurability (EOI) application either online or on paper:

- **Online at www.sunlife-usa.com/planmembers**

Our secure online system allows employees to provide all of the information needed for Evidence of Insurability in about 10 to 15 minutes. Following completion of the application, the employee receives confirmation by email. The employee then will receive notification of our decision by email or mail.

- **Printable EOI application**

If submitting the EOI application on paper, the applicant must include this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

Employee/Dependent Information (To be completed by employer)

Employee Name (first, middle initial, last)		Group Policy Number 07528	
Social Security Number (last four digits)	Approval Requested for	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent Child(ren):	<input type="checkbox"/> Spouse No. of Children:

Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverage(s) for which EOI is required. Fill in Current Amount of coverage, or the Guaranteed Issue (GI) amount of the plan. Then fill in Requested Amount and Amount Subject to EOI. Sign and date here if employee is submitting the printable EOI form.

Life Insurance

	Current Amount of Coverage (or GI)	Requested Amount	Amount Subject to EOI
<input type="checkbox"/> Employee Basic	\$	\$	\$
<input type="checkbox"/> Employee Optional	\$	\$	\$
<input type="checkbox"/> Spouse Basic	\$	\$	\$
<input type="checkbox"/> Spouse Optional	\$	\$	\$
<input type="checkbox"/> Child Optional	\$	\$	\$

Other Coverages

<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Buy-Up LTD: \$

Signature of person completing this cover page (Employer) X	Date
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Need help determining EOI? Please see your **Group Policy** and the **Administrator's Guide**.

Employee Instructions

Complete and submit either the **Online EOI Application** or the **Printable EOI Application**, but **not both**.

- **Online EOI Application**

1. Go to www.sunlife-usa.com/planmembers and click on Start under Evidence of Insurability
2. Follow the instructions on the web site. Enter height weight, date of birth and medical history for you and any dependents on this application. Use the information supplied by your employer above to complete the Coverage Information section of the online application. Your application will not be submitted until you click the Submit for Review button on the last screen.

- **Printable EOI Application**

1. Complete pages 1 and 2 of the EOI Application according to the instructions. You may type your answers into the fillable form and then print the document. Please remember to sign and date the form.
2. Mail or Fax the EOI Application and this Employer Cover Page to us:

MAIL TO: WELS Benefit Plans Office
2949 N. Mayfair Rd. Second Floor
Milwaukee, WI 53222

-or- FAX TO: (414) 256-3879

Sun Life Assurance Company of Canada

Evidence of Insurability Application – Health Questionnaire



I Applicant Information (Please print clearly)

Complete and return pages 1 and 2 of this form, along with the employer cover page to:

WELS Benefit Plans Office
2949 N Mayfair Rd. 2nd Floor
Milwaukee, WI 53222

Fax: (414) 256-3879

Your name (first, middle initial, last)		Name of your employer WELS VEBA Group Health Care Plan		Group policy no. 07528	
Your street address			City	State	Zip Code
Social Security number - -		Daytime phone number		E-mail address	

This Application is for: Employee Spouse Child Male Female

Name (if different than above)	Date of birth (m/d/y)	Height ft. in.	Weight lbs.
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II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

Important: You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 2 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

1. In the past five years, have you:

- a. Had transplant surgery, other surgery, injuries or been treated in a hospital?..... Yes No
- b. Been treated for alcoholism or advised by a physician to change your drinking habits?. Yes No
- c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? Yes No
- d. Been off work for more than five consecutive days due to illness or injury? Yes No
- e. Lost 20 lbs. or more over a 12 month period?..... Yes No

2. In the past five years, have you been diagnosed with, treated for or had any symptoms relating to any of the conditions listed below?

- a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder Yes No
- b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder Yes No
- c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack Yes No
- d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs Yes No
- e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder Yes No
- f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus Yes No
- g. Sugar in urine, diabetes, kidney or bladder disorder Yes No
- h. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) Yes No
- i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder Yes No
- j. Disorders of the eyes or ears Yes No
- k. Chronic fatigue or fibromyalgia Yes No

3. Are you currently pregnant? Yes No

Domiciliary State – Michigan

Continued on next page

III Activities

Important: If you answer “Yes” to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

Do you engage in any of the following activities?

- a. Skydiving Yes No
- b. Scuba diving..... Yes No
- c. Vehicle or boat racing Yes No
- d. Piloting an aircraft..... Yes No

IV Detail (Provide detail below about any “Yes” answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you need more room, check here and attach a separate sheet.

V Signature

Please read the Certification and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

Certification

I hereby certify, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me the Fraud Warning for my state on Page 3.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada (“The Company”) determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- If I have any questions regarding my EOI Application, I can write to Sun Life Assurance Company of Canada, Group Medical Underwriting – SC 7190, 15 Rye Street, Portsmouth, NH 03801.

Signature of Employee X	Date signed
Signature of Spouse (If Application is for spouse) X	Date signed

Sun Life Assurance Company of Canada

Please read the applicable fraud warning before signing this form.

State Law requires us to notify you of the following:

Fraud Warning (for all states except those listed separately below): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning – Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – Louisiana: 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.

Fraud Warning – New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning – Oklahoma: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning – Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud Warning –Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

GROUP TERM LIFE OPEN FORM **ENROLLMENT AND BENEFIT SUMMARY**

The WELS VEBA, in conjunction with The Sun Life Assurance Company of Canada (Sun Life), offers an Optional Group Term Life insurance program to all eligible active workers. This program may help your family by providing valuable protection when financial help is most needed.

OPTIONAL LIFE To help you meet this need, you have the opportunity to elect additional Group Term Life insurance to go along with any personal insurance coverage you may have.

OPTIONS There are several options, i.e. member coverage; member and spouse coverage; member, spouse and dependent coverage; member and dependent coverage; and coverage amount options of \$10,000; \$25,000; \$50,000; \$75,000; \$100,000 and \$150,000.

COSTS Due to the economies inherent in group insurance, the cost is in most cases lower than comparable insurance on an individual basis. Your rate is based on the amount of insurance you request and your age. (The rate changes as you enter a new five year age bracket. Your age is calculated as of December 31 of each year). Enclosed is a rate schedule for members, spouses and dependents.

ELIGIBILITY An active worker who is hired or called to work at least 20 hours per week and for five or more months of the year. All eligible workers are required to either have WELS VEBA health care coverage or the worker's congregation must be enrolled in the WELS VEBA Health Care Plan.

ENROLLMENT (requests for up to \$25,000 for the worker and \$12,500 for the spouse) If you enroll within your open enrollment period which is within the first 60 days of your employment, you are eligible for up to \$25,000 without providing evidence of insurability (and your spouse is eligible for up to \$12,500 without providing evidence of insurability). Please complete and return the yellow enrollment form.

(Requests for greater than \$25,000) For you to obtain coverage above \$25,000 (\$12,500 for your spouse), the enrollee (and spouse) must provide proof of medical insurability (form enclosed – "Evidence of Insurability"). Complete the "Evidence of Insurability" form AND the enrollment (yellow) form, sign and date both forms and return them to the WELS Benefit Plans Office. If Sun Life desires additional information, they will contact you directly after reviewing the information you have supplied.

DEPENDENT CHILDREN COVERAGE Coverage for dependent child(ren) is from the time a newborn leaves the hospital to age 19 unless the dependent is a full-time student. Coverage for full-time dependent students extends to age 26.

COVERAGE LIMITS The member has the option of requesting \$10,000; \$25,000; \$50,000; \$75,000; \$100,000; or \$150,000. The spouse may request up to one-half of the worker's coverage. The dependent child(ren) coverage is a flat \$5,000 for each and every child in the family. Note: No member, spouse or dependent child can be covered under more than one policy. Also, in the event a member/worker dies who also has spouse and/or dependent child(ren) coverage, Sun Life will offer the spouse/dependent(s) the right of conversion without medical evidence of insurability. No other options, other than conversion, are available.

BENEFICIARY You have the right to designate the beneficiary of your choice under the Optional Group Term Life insurance program. Unless you notify us differently, the beneficiary for the spousal and dependent child(ren) coverage is always the “employee” listed on the enrollment form.

TERMINATION Benefits will end at 12:01 A.M. on the first day of the calendar quarter coincident with or following the earlier of your retirement or termination of employment, the cessation of the plan, or your failure to submit the required premium by the end of the first month of a quarter. Sun Life allows a **30-day** grace period. Failure to submit your premium **INTO OUR BANK LOCKBOX** by the end of the grace period will result in termination of the policy.

RE-ENROLLMENT Failure to pay the premium within the time period noted above will result in the necessity for submission of a long form (medical underwriting) and possibly, a physical exam, in order to re-enroll. If premiums are received after the end of the grace period, we will refund the premium. You will have to notify us if you wish to re-enroll. Reinstatement will depend upon Sun Life’s acceptance. NOTE: After the initial enrollment, an individual will be accepted for re-enrollment via medical underwriting/medical exams only two (2) additional times. The only opportunity for re-enrollment beyond that will be if/when there is a complete open enrollment of members.

EFFECTIVE DATE Coverage is effective for three month (calendar quarter) periods only. If your enrollment is accepted by Sun Life, coverage will begin according to the following schedule:

Date of notification of your...	
<u>Acceptance from Sun Life:</u>	<u>Coverage Effective:</u>
Oct. 16 – Jan. 15	January 1
Jan. 16 – April 15	April 1
April 16 – July 15	July 1
July 16 – Oct. 15	October 1

INITIAL PREMIUM Do **NOT** include a premium payment with your enrollment forms. We will bill you.

WHERE BILLS ARE SENT Group Term Life billings for coverage are billed directly to the payor – either the individual policyholder or the respective Sponsoring Organization.

GUARANTEED ISSUE If you apply within the 60 day open enrollment period, you can be assured of at least \$25,000 regardless of your health. To choose that, respond “YES” to the question on the bottom of the cover letter (right below the “Service Type” question).

Sun Life Group Term Life Rates

(Available to VEBA Policyholders who are actively at work)

*(Conversion Policy is available when policyholder is no longer working. Please refer to your Group Life Plan Booklet)

Employee Coverage

Age	\$10,000 Coverage Limit			\$25,000 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$10,000	2.40	9.60	\$25,000	6.00	24.00
35-39	\$10,000	2.70	10.80	\$25,000	6.75	27.00
40-44	\$10,000	3.00	12.00	\$25,000	7.50	30.00
45-49	\$10,000	4.50	18.00	\$25,000	11.25	45.00
50-54	\$10,000	6.90	27.60	\$25,000	17.25	69.00
55-59	\$10,000	12.90	51.60	\$25,000	32.25	129.00
60-64	\$10,000	19.80	79.20	\$25,000	49.50	198.00
65-69	\$10,000	38.10	152.40	\$25,000	95.25	381.00
70-74	\$6,500	40.17	160.68	\$16,250	100.43	401.70
75-79	\$4,500	27.81	111.24	\$11,250	69.53	278.10
80+	\$3,000	18.54	74.16	\$7,500	46.35	185.40

Age	\$50,000 Coverage Limit			\$75,000 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$50,000	12.00	48.00	\$75,000	18.00	72.00
35-39	\$50,000	13.50	54.00	\$75,000	20.25	81.00
40-44	\$50,000	15.00	60.00	\$75,000	22.50	90.00
45-49	\$50,000	22.50	90.00	\$75,000	33.75	135.00
50-54	\$50,000	34.50	138.00	\$75,000	51.75	207.00
55-59	\$50,000	64.50	258.00	\$75,000	96.75	387.00
60-64	\$50,000	99.00	396.00	\$75,000	148.50	594.00
65-69	\$50,000	190.50	762.00	\$75,000	285.75	1,143.00
70-74	\$32,500	200.85	803.40	\$48,750	301.28	1,205.10
75-79	\$22,500	139.05	556.20	\$33,750	208.58	834.30
80+	\$15,000	92.70	370.80	\$22,500	139.05	556.20

Age	\$100,000 Coverage Limit			\$150,000 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$100,000	24.00	96.00	\$150,000	36.00	144.00
35-39	\$100,000	27.00	108.00	\$150,000	40.50	162.00
40-44	\$100,000	30.00	120.00	\$150,000	45.00	180.00
45-49	\$100,000	45.00	180.00	\$150,000	67.50	270.00
50-54	\$100,000	69.00	276.00	\$150,000	103.50	414.00
55-59	\$100,000	129.00	516.00	\$150,000	193.50	774.00
60-64	\$100,000	198.00	792.00	\$150,000	297.00	1,188.00
65-69	\$100,000	381.00	1,524.00	\$150,000	571.50	2,286.00
70-74	\$65,000	401.70	1,606.80	\$97,500	602.55	2,410.20
75-79	\$45,000	278.10	1,112.40	\$67,500	417.15	1,668.60
80+	\$30,000	185.40	741.60	\$45,000	278.10	1,112.40

* Dependent Child(ren) coverage of \$5,000/Child: 3 Month Premium = \$1.83 | Annual Premium = \$7.32

Sun Life Group Term Life Rates

(Available to Spouses of VEBA Policyholders who are actively at work)

*(Conversion Policy is available when policyholder is no longer working. Please refer to your Group Life Plan Booklet)

Spouse Coverage

Age	\$5,000 Coverage Limit			\$12,500 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$5,000	1.20	4.80	\$12,500	3.00	12.00
35-39	\$5,000	1.35	5.40	\$12,500	3.38	13.50
40-44	\$5,000	1.50	6.00	\$12,500	3.75	15.00
45-49	\$5,000	2.25	9.00	\$12,500	5.63	22.50
50-54	\$5,000	3.45	13.80	\$12,500	8.63	34.50
55-59	\$5,000	6.45	25.80	\$12,500	16.13	64.50
60-64	\$5,000	9.90	39.60	\$12,500	24.75	99.00
65-69	\$5,000	19.05	76.20	\$12,500	47.63	190.50
70-74	\$3,250	20.09	80.34	\$8,125	50.21	200.85
75-79	\$2,250	13.91	55.62	\$5,625	34.76	139.05
80+	\$1,500	9.27	37.08	\$3,750	23.18	92.70

Age	\$25,000 Coverage Limit			\$37,500 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$25,000	6.00	24.00	\$37,500	9.00	36.00
35-39	\$25,000	6.75	27.00	\$37,500	10.13	40.50
40-44	\$25,000	7.50	30.00	\$37,500	11.25	45.00
45-49	\$25,000	11.25	45.00	\$37,500	16.88	67.50
50-54	\$25,000	17.25	69.00	\$37,500	25.88	103.50
55-59	\$25,000	32.25	129.00	\$37,500	48.38	193.50
60-64	\$25,000	49.50	198.00	\$37,500	74.25	297.00
65-69	\$25,000	95.25	381.00	\$37,500	142.88	571.50
70-74	\$16,250	100.43	401.70	\$24,375	150.64	602.55
75-79	\$11,250	69.53	278.10	\$15,875	98.11	392.43
80+	\$7,500	46.35	185.40	\$11,250	69.53	278.10

Age	\$50,000 Coverage Limit			\$75,000 Coverage Limit		
	Coverage Amount	3 Month Premium	Annual Premium	Coverage Amount	3 Month Premium	Annual Premium
<35	\$50,000	12.00	48.00	\$75,000	18.00	72.00
35-39	\$50,000	13.50	54.00	\$75,000	20.25	81.00
40-44	\$50,000	15.00	60.00	\$75,000	22.50	90.00
45-49	\$50,000	22.50	90.00	\$75,000	33.75	135.00
50-54	\$50,000	34.50	138.00	\$75,000	51.75	207.00
55-59	\$50,000	64.50	258.00	\$75,000	96.75	387.00
60-64	\$50,000	99.00	396.00	\$75,000	148.50	594.00
65-69	\$50,000	190.50	762.00	\$75,000	285.75	1,143.00
70-74	\$32,500	200.85	803.40	\$48,750	301.28	1,205.10
75-79	\$22,500	139.05	556.20	\$33,750	208.58	834.30
80+	\$15,000	92.70	370.80	\$22,500	139.05	556.20

* Dependent Child(ren) coverage of \$5,000/Child: 3 Month Premium = \$1.83 | Annual Premium = \$7.32