SHELTERPOINT
Enrollment/Change Form

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

ShelterPoint Life Insurance Company administered by Pro Benefits Administrators

Type of Coverage	☑ Dental						
Policy No.	1178						
Policyholder (Employer):	Gramd Island Chamber of Commerce						
☐ **New Enrollment**	☐ New Employee ☐ Open Enrollment ☐ Rehire						Date:
☐ **Change Enrollment**	☐ New Address ☐ Name Change, Previous Name:						Date:
☐ **Add** ☐ **Change** ☐ **Cancel** **Spouse/Domestic/Civil Union Partner and/or Dependent**							Date:

A. Employee Information

Name (Last, First)		Gender ☐ M ☐ F	Date of Birth
Street Address			Date of F/T Hire
City	State	ZIP	Hours worked per week
Social Security No.			Annual Salary $
Job Title	Home Phone		Work Phone

B. Spouse/Domestic/Civil Union Partner & Dependent Coverage (*If more space is needed, attach extra copies.*)

Spouse/Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		☐ M ☐ F	☐ Add ☐ Cancel	☐ Marriage ☐ Divorce ☐ Death

	Child's Name (Last, First)	F/T Student	Date of Birth	Gender	Request to	Reason
1		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
2		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
3		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other

C. Beneficiaries for LTD and AD&D – Benefits are payable to estate of the deceased unless otherwise indicated.

☐ Add beneficiary ☐ Change existing beneficiary to individual(s) below: (*If more space is needed, attach extra copies.*)

Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:					
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship

D. Participation/Waiver

☐ Request to Participate: I hereby request to participate in the program. I agree to contribute as required.

☐ Waiver of Insurance (not participating)	I do not wish to participate. I understand that if I wish to participate at a later date, my benefits may be denied or reduced. Declined for: ☐ Self: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Accidental Injury ☐ Hospital Cash ☐ Excess Medical ☐Spouse/Partner: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Accidental Injury ☐ Hospital Cash ☐ Excess Medical ☐Dependent: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Accidental Injury ☐ Hospital Cash ☐ Excess Medical Reason: ☐ Spouse/Partner's Plan ☐ Not interested ☐ Other Plan, please specify:

LTD: ☐ I am not currently disabled and I am performing all duties required for my job on a full-time basis.

The information provided above is true and complete to the best of my knowledge and belief.

***NOTICE*:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature _____ **Date** _____