

Gerber Life Insurance Company 1311 Mamaroneck Avenue White Plains, NY 10605 (914)272-4000

## Administered by ProBenefits Administrators, on behalf of Gerber Life Insurance Company

Type of Coverage	☑ Dental								
Plan Options	ptions								
Policy No.	1178								
Policyholder (Employer):	Grand Island	Grand Island Chamber of Commerce							
☐ New Enrollment		☐ New Employee ☐ Open Enrollment ☐ P/T to F/T Status ☐ Rehire					Date:		
Select Coverage    Employee;   Employee+Spouse/Domestic Partner;   Employee +Child;   Family									
□ Change Enrollment □ New Address □ Name Change, Previous Name:								Date:	
□ Add □ Change □ Cancel Spouse/Domestic 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			State	e ZIP		Hours worked per week			
Social Security No.				<u>,</u>		Annual Salary \$			
Job Title Hom			Home Phone	me Phone		Work / Other Phone			
B. Spouse/Dom	estic Partner & Dep	endent Cove	erage (If more	e space is needed	l, attach extr	a copies.)			
Spouse/Domestic Partner's Name (Last, First)			Date of Bi	Date of Birth		Request to	Reason		
					□ M □ F	☐ Add ☐ Cancel		arriage vorce □ Death	
Child's Name (Last, First)			F/T Student	Date of Birth	Gender	Request to	Reas	on	
1			ΠY		ΠМ	□ Add		th   Adoption	
			□ N □ Y		□ F □ M	☐ Cancel☐ Add		ath □ other th □ Adoption	
2			□N		□F	☐ Cancel	□ De	ath □ other	
3			□ Y □ N		□M □F	<ul><li>□ Add</li><li>□ Cancel</li></ul>	☐ Birth ☐ Adoption☐ Death☐ other☐		
C. Participation/Waiver									
□ Request to Participate: I hereby request to participate in the program. I agree to contribute as required.									
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.									
☐ Waiver of Insurance									
(not participating)									
Reason: Spouse/Domestic Partner's Plan Not interested Other Plan, please specify:									

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If you have questions about the benefits provided by this coverage, please contact us at 1-888-683-3682.

<u>NOTICE</u>: 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 \$5,000 and the stated value of the claim for each such violation.

Signature	Date	
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The information provided above is true and correct to the best of my knowledge and belief.

Please send Completed Enrollment Form to: ProBenefits Administrators 100 Corporate Pkwy, Suite 334 Amherst, NY 14226

Tel. 1-888-683-3682 Fax: 716.831.8080

Email: pbaenrollments@probenefitsadmin.com

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