Sun Life and Health Insurance Company (U.S.)

One Sun Life Executive Park, Wellesley Hills, MA 02481 800-247-6875

Group Enrollment form for Dental Insurance

Employer use (check one): ☐ New employee ☐ Change ☐ COBRA

1 General information

Employer name	Account/policy number	Location
New York State PEF Retirees	935636	

2 Employee information

Employee's Full Legal Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth

Street Address	City	State	Zip Code

Occupation	Eligibility class (if applicable)	Social Security number	Phone number

Date employed: ☐ Full-Time Date: ☐ Return from layoff Date:
☐ Part-Time Date: ☐ Rehire

Current Active Employment Type	Earnings $
_____ # of hours ☐ Full-Time ☐ Part-Time	☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: _________

3 Dependent information

Please complete this entire section if you are selecting dependent coverage. No employee can be insured as a dependent when he/she is also insured as an employee for any benefit under the same policy.

If more space is needed, please add additional pages.

Relationship	Full legal name (First, MI, Last)	Gender	Social Security number	Date of birth	Student Y / N
Spouse / partner					
Children					

4 Benefit elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies and service providers above and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

Elect	Refuse	Coverage
☐	☐	Dental: ☐ Employee ☐ Employee + 1 Dependent ☐ Employee + Family Were you covered under another dental plan within the last 31 days? .... ☐ Yes ☐ No If "Yes," provide the termination date: _______________________ Reason for termination of coverage? __________

5 Signature and authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- For Dental coverage, I understand that I will not be entitled to benefits until the expiration of any Late Entrant benefit waiting period specified in the certificate of insurance.
- For Dental Insurance plans, I have the right to select any dental care provider of my choice.
- The dental plan includes a pre-determination provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.
- Coverages include benefit waiting periods, limitations, and exclusions that may affect my entitlement to benefits.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, 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 confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief. I have read or had read to me the fraud warning for my state.

Does not apply to Life Insurance. 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.

X ____ ____________________

Employee Signature Today's Date

To the Employee: Make a copy of this form for your records before submitting it to:

PEF Retirees Dental Program
c/o Sun Life
Member Adjustment Dept., W460
P.O. Box 725
Windsor, CT 06095-9950

Contact us

By mail
PEF Retirees Dental Program c/o Sun Life
Member Adjustment Dept., W460
P.O. Box 725
Windsor, CT 06095-9950

www.PEF.org

Customer Service **844-738-8118** M–F 8:00 a.m. – 8:00 p.m., ET