Sun Life and Health Insurance Company (U.S.)
96 Worcester Street, Wellesley Hills, MA 02481 800-247-6875

Group Enrollment form for Dental Insurance

1 General information

Policyholder name NYS PEF Retirees		Account number 935636	
Street address P.O. Box 5619	City Hartford	State CT	Zip code 06102-5619
Type of activity: ☐ New Enrollment ☐ Change Reason:			

2 Member information

Member's Full Legal Name (First, MI, Last)		☐ Male ☐ Female	Date of Birth
Street Address	City	State	Zip Code
Marital Status	Email Address	Phone number	
Member Status: ☐ Active Union ☐ Retired		Member ID #:	Social Security number

You need to complete all sections of the enrollment form and sign it. This must be done either during the enrollment period or within 240 days of your eligibility date. PEF Membership Benefits Program will inform you which benefits are available. If after 240 days, please complete an online EOI, at www.mysunlifebenefits.com.

3 Benefit elections

Dental coverage:

If you refuse Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the plan certificate of coverage. For more information, please contact PEF Retiree Dental Program.

Dental ☐ Elect..... ☐ Refuse
- ☐ Member
- ☐ Member + 1
- ☐ Family

The policy/certificate provides dental benefits only. Review your policy/certificate carefully.

4 Dependent information

Please complete this entire section if you are selecting dependent coverage. You must complete this section if you elected coverage for your Spouse[1] / Partner and/or child(ren).

Relationship	Full Legal Name (First, MI, Last)	Gender	Social Security No.	Date of Birth
Spouse[1] / Partner			XXX-XX-	
Children			XXX-XX-	
			XXX-XX-	
			XXX-XX-	

☐ I understand Spousal[1] / Partner coverage is for married individuals or those who have executed domestic partnership forms on file with PEF Retirees Dental Program. If I have a change in my marital status, I must contact PEF Retirees Dental Program as soon as possible.

☐ I understand dependent children must be under the age of 19 years old or unmarried and under the age of 25 enrolled as a full-time student and who depends on me for 50% or more for his/her support. Not applicable to Life or Dental.

☐ For Dental: I understand dependent children must be unmarried and under the age of 26 and chiefly dependent on me for support and maintenance.

5 Authorization information

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.

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 _____ _____

Member Signature Today's Date

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

PEF Retiree Dental Program
c/o Sun Life
P.O. Box 5619
Hartford, CT 06102-5619

844-738-8118
pefenrollment@sunlife.com
Fax: 844-295-7779

This original enrollment form should remain at Your Policyholder's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment form.

[1] You must be legally married to enroll someone as a spouse.

Contact us

By mail:
PEF Retiree Dental Program
c/o Sun Life
P.O. Box 5619
Hartford, CT 06102-5619

www.PEFretirees.org

Sun Life Customer Service
1-844-738-8118

M–F 8:00 a.m. – 8:00 p.m., ET