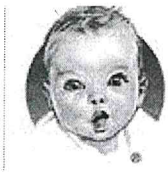

Gerber Life Insurance

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	☐ Employee	☐ Emp/Spouse	☐ Emp/Child	☐Family		
Policy No.	**10444-01**						
Policyholder (Employer):	**FRANKFORT-SCHUYLER CSD**						
☐ **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	Social Security
		☐ M ☐ F	☐ Dental ☐ Vision	

	Child's Name (Last, First)	F/T Student	Date of Birth	Gender	Request to	Social Security
1		☐ Y ☐ N		☐ M ☐ F	☐ Dental ☐ Vision	
2		☐ Y ☐ N		☐ M ☐ F	☐ Dental ☐ Vision	
3		☐ Y ☐ N		☐ M ☐ F	☐ Dental ☐ Vision	
4		☐ Y ☐ N		☐ M ☐ F	☐ Dental ☐ Vision	
5		☐ Y ☐ N		☐ M ☐ F	☐ Dental ☐ Vision	

C. 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 ☐ Spouse/Dom. Partner: ☐ Dental ☐ Dependent: ☐ Dental Reason: ☐ Spouse/Domestic Partner's Plan interested ☐ Not ☐ Other Plan, please specify:

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

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** _____

HR DEPT - Please send Completed Enrollment Form to:
ProBenefits Administrators / Email: pbaenrollments@probenefitsadmin.com
100 Corporate Pkwy, Suite 334