



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	<input type="checkbox"/> Dental						
Plan Options	<input type="checkbox"/> Starter <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 1A <input type="checkbox"/> Level 1C <input type="checkbox"/> Custom						
Policy No.							
Policyholder (Employer):							
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> New Employee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> P/T to F/T Status <input type="checkbox"/> Rehire						Date:
Select Coverage	<input type="checkbox"/> Employee; <input type="checkbox"/> Employee+Spouse/Domestic Partner; <input type="checkbox"/> Employee +Child; <input type="checkbox"/> Family						
<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> New Address <input type="checkbox"/> Name Change, Previous Name:						Date:
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Spouse/Domestic Partner and/or Dependent						Date:

A. Employee Information				
Name (Last, First)		Gender <input type="checkbox"/> M <input type="checkbox"/> 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 / Other Phone	

B. Spouse/Domestic Partner & Dependent Coverage <i>(If more space is needed, attach extra copies.)</i>						
Spouse/Domestic Partner's Name (Last, First)		Date of Birth	Gender	Request to	Reason	
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death	
Child's Name (Last, First)		F/T Student	Date of Birth	Gender	Request to	Reason
1		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> other
2		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> other
3		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death <input type="checkbox"/> other

C. Participation/Waiver	
<input type="checkbox"/> Request to Participate: I hereby request to participate in the program. I agree to contribute as required.	
<input type="checkbox"/> 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. <u>Declined for:</u> <input type="checkbox"/> Self: <input type="checkbox"/> Dental <input type="checkbox"/> Spouse/Dom. Partner: <input type="checkbox"/> Dental <input type="checkbox"/> Dependent: <input type="checkbox"/> Dental Reason: <input type="checkbox"/> Spouse/Domestic Partner's Plan <input type="checkbox"/> Not interested <input type="checkbox"/> Other Plan, please specify:

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

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 \$5,000 and the stated value of the claim for each such violation.

Signature _____ Date _____

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