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						
Plan Options	☐ Starter ☐ Level 1 ☐ Level 1A ☐ Level 1C ☐ Custom						
Policy No.							
Policyholder (Employer):							
☐ 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	ZIP	Hours worked per week
Social Security No.			Annual Salary $
Job Title	Home Phone		Work / Other Phone

B. Spouse/Domestic Partner & Dependent Coverage (*If more space is needed, attach extra copies.)*

Spouse/Domestic Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		☐ M ☐ F	☐ Add ☐ Cancel	☐ Marriage ☐ Divorce ☐ Death

	Child's Name (Last, First)	F/T Student	Date of Birth	Gender	Request to	Reason
1		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
2		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
3		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other

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 ☐ Not interested ☐ 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